NHS
West Leicestershire
Clinical Commissioning Group

Paper D

WEST LEICESTERSHIRE CLINICAL COMMISSIONING GROUP
BOARD MEETING

10 September 2019

Title of the report:	Board Assurance Framework Update
Section:	Governance
Report by:	Stuart Fletcher – Head of Corporate Governance
Presented by:	Ket Chudasama – Director of Performance & Corporate Affairs

Report supports the following West Leicestershire CCG's goal(s):			
Improve health outcomes	✓	Improve the quality of health-care services	✓
Use our resources wisely	✓		

Equality Act 2010 – positive general duties:
1. The CCG is committed to fulfil its obligations under the Equality Act 2010, and to ensure services commissioned by the CCG are non-discriminatory on the grounds of any protected characteristics. 2. The CCG will work with providers, service users and communities of interest to ensure if any issues relating to equality of service within this report are identified and addressed.

Additional Paper details:	
Please state relevant Constitution provision	Section 6.6.1(a) - ensuring that the Group has appropriate arrangements in place to exercise its functions effectively, efficiently and economically and in accordance with the Group's principles of good governance
Please state relevant Scheme of Reservation and Delegation provision (SORD)	N/A
Please state relevant Financial Scheme of Delegation provision	N/A
Please state reason why this paper is being presented to the WLCCG Board	To update the Board on the CCG's key strategic and operational risks as at 3 September 2019 To seek approval of a revised BAF risk escalation process
Discussed by	Risks escalated to the BAF from each Committee Risk Register have been reviewed during the quarter by the Corporate Management Team.
Alignment with other strategies	Operational Plan
Environmental Implications	None Identified
Has this paper been discussed with members of the public and other stakeholders, if so please provide details	No

EXECUTIVE SUMMARY:

1. This report prepared for the Governing Body is presented in two parts:

   a. The Board Assurance Framework (BAF) as at the beginning of September 2019;
   b. Proposals to harmonise the current BAF as part of our next steps towards Leicester, Leicestershire and Rutland collaborative working arrangements.

2. Part A

   The BAF document aims to identify the strategic risks to the delivery of the CGG's objectives. It sets out the actions that are in place to manage the risks and the arrangements to monitor whether these are having the desired impact.

   The BAF has been reviewed and updated by the relevant leads to show the latest position as at the 3 September 2019, which is attached in Appendix 1.

   The total number of risks appearing on the BAF as at 3 September is 29, this remains the same as quarter 1 2019.

3. Part B

   The Governing Body has received updates regarding the LLR collaborative governance proposals at the Joint Board meeting in July. As part of the wider governance work coordinated through the Governance Working Group (GWG) this also includes how the three CCGs can begin to align their statutory policies and risk management approaches in preparation for closer working arrangements.

   The quarter 1 BAF was presented to the July Governing Body meeting. As part of this report, a new BAF template was introduced as part of the wider risk management work. It was agreed that further work is needed towards the development of an LLR BAF; however, is was noted that that there is a need for standardisation.

   The GWG has been reviewing the consistency of risk reporting across the three LLR CCGs. The three CCGs have strong commonality across the strategic risks within their BAFs; however, WLCCG's BAF has been noted to include a higher number of risks that may be considered to be more 'operational'.

   Board members are asked to consider revising our risk escalation approach as a first step towards harmonising our BAF. This proposal would then provide following benefits to the Governing Body:

   - A BAF this is more focused on the current strategic risks;
   - Provide assurance that the operational risks continue to be managed and reviewed on the respective committee risk registers;
   - To provide the Governing Body with a clear rationale for the escalation of an operational risk (rated as 12 or above) from a committee risk register to the BAF on that understanding that it requires Governing Body oversight.

RECOMMENDATIONS:

West Leicestershire CCG Board is asked to:

APPROVE the Board Assurance Framework as at the beginning of September 2019

DISCUSS the proposed refreshed BAF risk escalation process from sub committees

APPROVE the revised BAF risk escalation process and amended Risk Management Strategy & Policy (Appendix 2)

DISCUSS if any further actions are required to address the risks reported

DISCUSS whether any of the risks listed in the table at para. 18 should be de-escalated from the BAF and managed through the respective committee risk register

WEST LEICESTERSHIRE CLINICAL COMMISSIONING GROUP
BOARD MEETING

10 September 2019

BOARD ASSURANCE FRAMEWORK

INTRODUCTION

Part A

1. The Board Assurance Framework (BAF) has been reviewed and updated and shows the latest position as at 3 September 2019. The updated BAF contains risks to the achievement of strategic objectives for the year. Currently, the BAF also includes other risks escalated from the constituent risk registers where there is an inherent risk rating of 12 or more. The BAF is appended to this paper as Appendix 1.

2. Each risk register is a live document and is maintained by the relevant committee responsible for that business area. In addition the Corporate Management Team (CMT) reviews the Corporate Risk Register on a quarterly basis. The Audit Committee provides further scrutiny and challenge on the risk registers and BAF. The detailed registers are available to Members for review at any time. The risks were last reviewed by the committees as follows:

    - F&P Risk Register at July F&P meeting;
    - PCCC Risk Register at July PCCC meeting;
    - Q&P Risk Register at Q&P meetings in March, (May & July for info) and a virtual review of risks by CMT leads in September;
    - Corporate Risk Register at CMT in September.

CURRENT POSITION

3. As at 3 September 2019 there were 15 red rated risks:

Risk ref	Description	Score as at 3 Sept	Change from Q1
BAF/049 (PCCC/11)	Implementation of GP Forward View	16	⟷
BAF/060 (Q&P/EMAS 01)	Ambulances unable to attend in timely response	16	⟷
BAF/080 (Q&P/EMAS 02)	Failure to meet ARP standards	20	⟷
BAF/077 (Q&P/EMAS 03)	A high number of prolonged waits were identified in December 2017 as causes of Si's prompting co-ordinating commissioners to initiate review under GC8	16	⟷
BAF/039 (FP/RR/03)	Failure to assure in year local health economy financial viability	16	⟷

BAF/001 (FP/RR/29)	Failure to assure local health economy financial viability over the next five years	20	⟺
BAF/009 (FP/RR/30)	Failure to maintain control of CCG financial position and deliver statutory duty to breakeven over the coming 5 year planning period	16	⟺
BAF/062 (FP/RR/33	Failure to control prescribing spend leading to significant overspends in year	15	⟺
BAF/084 (FP/RR/68)	Failure to deliver a robust, deliverable, financially balanced Plan for 19/20	16	⟺
BAF/067 (CRR/35)	Risk to staff morale and productivity due to uncertain LLR future	16	⟺
BAF/047 (CRR/55)	Provider at Hinckley Hospital has flagged risk of cross infection in endoscopy decontamination department	16	⟺
BAF/088 (CRR/65)	Patient safety and experience could be compromised due to TASL's operational performance, quality monitoring systems and long term financial sustainability	16	⟺
BAF/071 (LLR/IG RR/15)	Increasing threat of cyber crime	16	⟺
BAF/089 (FP/RR/69)	Failure to maintain control of CCG financial position and deliver statutory duty to break even in 19/20	16	⟺
BAF/090 (FP/RR/70)	Failure to deliver planned levels of QIPP savings in 19/20	15	⟺

RISK COMPARISON –Q1

4. The total number of risks appearing on the BAF as at 3 September is 29, this remains the same as in quarter 1 2019. However, one risk has reduced from a net risk score of 16 to 12 and this is risk 079 – TASL fail to provide quality reports in line with quality schedule.

Part B - Proposals to harmonise the BAF

5. The Governing Body has received updates regarding the LLR collaborative governance proposals at the Joint Board meeting in July. As part of the wider governance agenda, the Governance Working Group (GWG) has also been reviewing how the three CCGs can begin to align their statutory policies and risk management approaches in preparation for closer working arrangements.

6. The quarter 1 BAF was presented to the July Governing Body meeting. As part of this report, a new BAF template was introduced as part of the wider risk management work. It was agreed that further work is needed towards the development of an LLR BAF; however, is was noted that that there is a need for standardisation.

7. The principal feedback was around the value the new template would provide to the governing body, and that during the transition period that reources might be better placed to ensure the set of strategic objectives across LLR are similar.

8. The GWG has therefore been reviewing the consistency of risk reporting across the three LLR CCGs. The three CCGs have strong commonality across the strategic risks within their BAFs; however, WLCCG's BAF has been noted to include a higher number of risks that may be considered to be more 'operational'.

9. The current CCG Risk Management Strategy & Policy (updated in November 2018) describes in section 8 the interrelationship between the risk registers and the BAF:

9 Board Assurance Framework (BAF)

9.1 A two-tier process involving the risk registers and the BAF has been implemented. The aim of the two tier approach is to ensure that the bigger strategic picture does not become clouded by day to day risk management issues.

9.2 A threshold for escalating risks to the BAF has been set using the 5 x 5 risk rating matrix, whereby any risk that has a net risk score of 12 or above must be reported on the BAF. However, this should be discussed with the Corporate Management Team initially to establish whether there is a case for the risk to be escalated to the BAF even if the rating is below 12.

9.3 When risks are escalated to the BAF, they still remain on the relevant risk register. This ensures more detailed scrutiny and management by people closer to the issue.

10. Whilst this approach has been transparent in escalating operational risks above 12 to the BAF, it has resulted in a BAF document that may not provide a clear focus on the key risks that are impacting on our objectives.

LLR position - comparison

11. Leicester City CCG reported to their June Governing Body that 7 live risks were recorded on their BAF. Leicester City operates a two tier process involving local directorate based risk-registers and the BAF. The risks include are scored between 15 and 25 (inherent) with a residual risk of 12 and above. These risks are linked to the NHS Mandate Objectives. Any risks that have an inherent risk score of 15 or above must be reported on the GBAF; however, this is discussed with the Head of Corporate Affairs to establish whether there is a case for the risk to be escalated to the GBAF.

12. East Leicestershire & Rutland CCG has 14 risks on its BAF. It also operates a two tier approach similar to WLCCG to ensure that the strategic picture does not become clouded by the day to day risk management issues that are considered to be managed at a local level. Notwithstanding this, there is a clear route for significant local issues to influence the strategic risk profile. Therefore the risks include are scored between 15 and 25 (inherent) with a residual risk of 12 and above.

13. The current WLCCG BAF includes 29 risks, which are comprised of:

Risk score	Number of risks
12	13
15	2
16	12
20	2

14. In order to support the next steps around closer working arrangements, the Governing Body are asked to consider revising our risk escalation approach in our Risk Management Policy (section 8) as a first step towards harmonising our BAF. This proposal would provide following benefits to the Governing Body:

    - A BAF this is more focused on the current strategic risks;
    - Provide assurance that the operational risks continue to be managed and reviewed on the respective committee risk registers;
    - To provide the Governing Body with a clear rationale for the escalation of an operational risk (rated as 12 or above) from a committee risk register to the BAF on that understanding that it requires Governing Body oversight.

15. It is therefore proposed that WLCCG adopt a similar approach with that of LCCCG and EL&RCCG so that the risks on the BAF are scored between 15 and 25 (inherent) with a residual risk of 12 and above.

16. Notwithstanding this, the CCG is cognisant that some operational risks are also capable in damaging the long-term viability or reputation of the organisation as the strategic risks. Therefore, it is proposed that in principle any risk that has a net risk score of 15 or above must be reported on the GBAF; however, any risk that has a net risk score of 12 is discussed with the Director of Performance & Corporate Affairs / Head of Corporate Affairs and the relevant Committee Chair to establish whether there is a case for the risk to be escalated to the BAF. This will consider factors such as the impact criteria outlined in Appendix 2 of the Risk Management Policy (impact to reputation, patient safety, financial costs etc).

17. To this end, the following risks in the below table are considered to be operational. It is proposed that for quarter 3 these are removed from the BAF; however, they will continue to reside on the respective committee risks register and be managed at a local level.

BAF Risk Ref:	Risk Description	Net Risk Score	Sub committee
052	Failure by IAPT to reach KPI targets in all three years	12	Q&P
061	The CCG fails to meet the NHSI ambition for the reduction in gram-negative blood stream infections for 2017/18	12	Q&P

078	Patient safety – TASL transport not arriving or arriving late, resulting in missed appointments, impacts on DTOC, patients missing care packages, rebeds etc.	12	Q&P
081	Providers failing to supply service due to errors in reprocurement processes	12	F&P

18. The following risks have a net risk score of 12 but currently remain on the BAF as they are considered strategic risks. However, Board members are asked to review these risks and agree whether any appear to be more operational and therefore better managed through the respective committee risk register:

BAF Risk Ref:	Risk Description	Net Risk Score	Sub committee
027	Threat to sustainability of GP workforce	12	PCCC
020	Increase in avoidable attendance at A&E from care homes	12	Q&P
082	Lack of leadership, capacity and capability across the system to deliver required transformation	12	F&P
085	Plans not delivering in terms of required performance improvement on key metrics	12	F&P
086	Lack of capacity/capability to influence QIPP delivery led by other organisations	12	F&P
087	Failure to deliver LLR-wide contracting, QIPP and service reconfiguration priorities	12	F&P
072	Decisions for STP are not made appropriately or in a timely manner	12	CRR
068	As a result of a failure to jointly agree future collaborative working arrangements, future and present collaborative working is delayed/fails to deliver its objectives	12	CRR
069	Delay in recruiting to a single AO and single executive team	12	CRR

Risk Management Policy & Strategy

19. In order to support the next steps in our closer working arrangements, the Governing Body are also asked to consider revising our risk escalation approach in section 8 of the Risk Management Policy in accordance with paragraph 16 of this report. This proposal would provide following benefits to the Governing Body:

    - A BAF this is more focused on the current strategic risks
    - Provides assurance that the operational risks continue to be managed and reviewed on the respective committee risk registers
    - To provide the Governing Body with a clear rationale for the escalation of an operational risk rated as 12 or above from a committee risk register to the BAF on that understanding that it requires Governing Body oversight.

20. The proposed wording would be as follows:

8 Board Assurance Framework (BAF)

8.1 A two-tier process involving the risk registers and the BAF has been implemented. The aim of the two tier approach is to ensure that the bigger strategic picture does not become clouded by day to day risk management issues.

New

8.2 A threshold for escalating risks to the BAF has been set using the 5 x 5 risk rating matrix, whereby any risk that has an inherent/net risk score of 15 or above must be reported on the BAF; however, any risk that has an inherent/net risk score of 12 is discussed with the Director of Performance & Corporate Affairs / Head of Corporate Affairs and the relevant Committee Chair to establish whether there is a case for the risk to be escalated to the BAF.

Previously

8.2 A threshold for escalating risks to the BAF has been set using the 5 x 5 risk rating matrix, whereby any risk that has a net risk score of 12 or above must be reported on the BAF. However, this should be discussed with the Corporate Management Team initially to establish whether there is a case for the risk to be escalated to the BAF even if the rating is below 12.

8.3 When risks are escalated to the BAF, they still remain on the relevant risk register. This ensures more detailed scrutiny and management by people closer to the issue.

21. Should Board members agree to this approach, our Risk Management Strategy & Policy will be amended as per tracked changes the attached version (Appendix 2), and a revised version of the BAF will be brought back in quarter 3 that will contain fewer operational risks and will therefore align more closely with the other two CCGs' BAFs.

NEXT STEPS

22. To present a revised version of the BAF in quarter 3 that will likely contain fewer operational risks and will therefore align more closely with the other two CCGs' BAFs.

23. To keep the WLCCG Board updated on the work being carried out by the GWG.

RECOMMENDATIONS:

West Leicestershire CCG Board is asked to:

APPROVE the Board Assurance Framework as at the beginning of September 2019

DISCUSS the proposed revised BAF risk escalation process

APPROVE the revised BAF risk escalation process and amended Risk Management Strategy & Policy

DISCUSS if any further actions are required to address the risks reported

DISCUSS whether any of the risks listed in the table at para. 18 should be de-escalated from the BAF and managed through the respective committee risk register

BOARD ASSURANCE FRAMEWORK - September 2019

Ownership			Caroline Trevithick, Interim Accountable Officer			CCG Board						Sept 2019/20	
Strategic Objectives (1-10) Organisational Goals (1-4)	Risk Ref.	Source	Risk Description	Risk Score: Impact	Existing Actions/Controls	Monitoring Mechanisms	Risk scores: Likelihood	Risk scores: Rating	Next steps	Risk Treatment	Exec Owner	Last Revised
SO - 4 OG - 1 & 2	BAF /027	Primary Care Co-commissioning Committee (PCCC)/02	**RISK** Threat to sustainability of GP workforce in terms of existing capacity and morale, retention and succession planning **CAUSE** National recruitment issues and an inability for some practices to meet the financial demands of GP applicants **IMPACT** Reduced access to GPs; impact upon clinical quality and patient safety	4	• LLR GP Workforce Group co-ordinating a range of initiatives to support supply, retention and recruitment of GP workforce, key work areas include: International Recruitment, Clinical pharmacists in general practice, local implementation of General Practice nursing ten point plan, GP Retention scheme, NHS GP Health Service. • NHS England Interim Workforce Implementation Plan to be published in June 2019 which will help set direction of LLR work. Completed recruitment appointment of STP First5 GP Clinical Lead. • NHS England support received for appointment of International GP Recruitment Project Manager & Workforce Development Lead. • NHSE funding secured for LLR Retention Plan. Plan to be completed Oct 2018 - March 2019.	• Primary Care Co-commissioning Committee (PCCC) • GP Workforce group • Federations are currently looking at resilience	3	12	• LLR LWAB Development session held on 10.07.19 to review new national guidance (NHS England Long Term Plan, People Plan and 5 Year GP (GMS) Contract Framework) to inform LLR workforce priorities, outcomes to inform work programme for GP Workforce. Group. Group to review capacity to deliver agreed work programmes. • Complete cohort 1 of the International GP Recruitment initiative with GPs being in general practice by August 2019. Potential 2 month delay in commencing with cohort 2 International GP Recruitment programme.	Control	Ian Potter Director of Primary Care	01-Jul-19
SO - 4, 5 & 9 OG - 1, 2 & 3	BAF/049	PCCC/11	**RISK** Implementation of GPFV at WLCCG and LLR level fails to address unprecendent challenges faced by General Practice **CAUSE** Resource contraints and conflicting priorities for LLR, WLCCG and GP staff. **IMPACT** Do not capatilise on opportunity to make changes which would support sustainability of general practice	4	LLR GP Programme Board established and leading implementation of the GPFV, key workstreams established across IM&T, Workforce. Capacity to take forward initiatives impacts on develpoment and delivery.	• Primary Care Co-commissioning Committee (PCCC) • GPPB	4	16	• 5 Year GP (GMS) Contract Framework and NSH Long Term Plan sets out new opportunities for general practice and the LLR system • Work is underway to understand and incorporate into 2019/20 plans the expectations of the national guidance and review current governance and leadership arrangements. • Increased focus on collaborative working across LLR to release resources to support development and implementation of plans key. Primary Care Co-commissioning Committee (PCCC) to remain as the Sub Group of the Board leading development and implementation for WLCCG.	Influence	Ian Potter Director of Primary Care	01-Jul-19
SO - 2, 3 & 4 OG - 1 & 2	BAF/052	Q&P RR/IAPT01	**RISK** Failure by IAPT to reach KPI targets in all 3 areas: • 6 week referral to treatment (75%) • Access rates (15%) • Recovery rates (50%) **CAUSE** staffing levels, referrals into the service, DNA and cancellations **IMPACT** Risk to patient safety,	4	• Performance notice issued 7th June, Performance notice meeting held 20th June. Follow up meeting held 18th July. Joint investigation is not being pursued at present, but a deep dive is taking place between commissioner, provider, NHS E and NHS I. Follow up meeting took place in March. The provider has committed to provide a finalised recruitment and retention plan, a timeline for direct access to Silver Cloud and a review of the branding end of April 2018. A Demand and capacity confirm and challenge meeting is taking place on 9th April with the Clinical Network, Commissioners and the Provider to discuss the current analysis. • Access: Working with LPT and public health to target school staff and UHL. A wider marketing campaign is in place and actions carried out. Working with UHL to increase access for people with LTCs. Development of Hub and Spoke model. Direct access clinic in Loughborough. Performance achieved in • 6 Week Waits: Performance is deteriorating as a result of low PWP staffing levels. Existing staff in service being used to minimise assessment waiting times. Developing a Hub and Spoke approach to increase staff productivity (reduction in travel time, better peer support). • MTR: maintain quality of treatment, ensure appropriate referrals are accepted.	•Monthly contract and performance meeting • Informal update reports • PPAG reports	3	12	• LLR Follow up to deep dive took place in March 2018 with a further follow up in July • Demand and Capacity confirm and challenge meeting taking place in April • Final timeline to be received re the recruitment and retention strategy . Identify the capacity required to clear the backlog . Creation of a timeline for Silver Cloud direct access . Review branding to potentially have one IAPT brand across LLR . Produce a timetable for Group therapy detailing locations, times, dates etc to share with GPs. . WL CCG has agreed to achieve 19% access rates in 18/19	Influence	Carole Ribbins Interim Chief Nurse and Quality Lead	01-Apr-19
SO - 3, 4 & 8 OG - 2, 3 & 4	BAF/060	Q&P RR / EMAS 01	**RISK** Ambulances unable to attend in a timely manner, and there is a failure to meet ARP standards **CAUSE** Delay in response times due to EMAS performance **IMPACT** Severity of harm	4	• Routine reporting of SI / incidents, review and sign off at regional level by EMAS and Hardwick CCG, and LLR level. • Range of actions in AEDB High Impact Action plan aimed at reducing handover delays • ECIP support • Charting protocol in escalation protocols	• AEDB (fortnightly) • Quarterly CADG meetings and monthly EMAS CCM meetings • EMAS have completed and closed the 'must do' and 'should do' CQC action plans Attendance at monthley SI peer review meetings • Two months of good handovers were experienced, but with no contingency arrangements – agreed the risk should remain as high.	4	16	•EMAS have produced a rapid handover flow-chart Continue to implement HIA plan •Monitor delivery of Quality Improvement Plan at both Regional and County levels through the agreed meeting structure and assurance groups • Bi-annual prolonged wait reviews for Cat 1 and Cat 2 did not identify any definitive harm as a result of prolonged wait. System learning to be presented at IUEC group.	Influence	Yasmin Sidyot Interim Director of Urgent & Emergency Care	01-Apr-19

Strategic Objectives (1-10) Organisational Goals (1-4)	Risk Ref.	Source	Risk Description	Risk Score	Existing Actions/Controls	Monitoring Mechanisms	Risk scores		Next steps	Risk Treatment	Exec Owner	Last Revised
				Impact			Likelihood	Rating				
SO - 3 & 8 OG - 1 & 2	BAF061	Q&P RR / 03	**RISK** The CCG fails to meet the NHSI ambition for the reduction in gram-negative blood stream infections for 2017/18 **CAUSE** Health economy complexities with information technology with no additional administration support across LLR challenges the required data collection / inputting **IMPACT** LLR not able to demonstrate improvement with gram negative blood stream infections	3	• Development of a LLR Multi-agency Healthcare Associated Infection Improvement Group (LLR MHAIIG). This group will have oversight of the LLR position in relation to infectious activity including trends and benchmarking. • LLR MHAIIG accountable to the Infection Prevention Programme Board to ensure that the LLR position is known at Board level. • Systems and processes across LLR under review to support more efficient and effective ways of working to support the NHSI ambition.	• Monthly performance monitoring of gram negative blood stream infections by IP&C Team. • Monthly LLR MHAIIG meeting where situation will be reviewed , monitored and reported quarterly to the Infection Prevention Programme Board.	4	12	Members of the LLR MHAIIG have agreed to support the development of an Infection Prevention (IP) Operational Group where LLR IP specialists will meet monthly. This group will review the ways in which IP is delivered across LLR. .Gram negative blood stream infections will continue to be reported via the existing LLR systems however, the NHSI required detail will be reduced until adequate resources in terms of administration and information technology are sought. 05.04.2018 It is likely that WLCCG will meet the 10% reduction of gram negative bacteria E.coli. However the data for March 18 cannot be confirmed until mid April 18. May 2018 - WLCCG met the 10% reduction target for E Coli bacteraemia cases in 2017/18. March 2019: Head of IPC is meeting with PHE to discuss WLCCG number of CDI cases and to interrogate the data held against the cases. This will determine whether further action is required. Hydration will form part of the LLR IPC MADG 2019/2020 work plan, to reduce the number of UTI's and GNBSI. End of year outturn will be discussed in the next LLR IPC MADG group to ascertain any lessons to be learnt from our other CCG across LLR.	Influence	Carole Ribbins Chief Nurse and Quality Lead	01-Apr-19
SO -4, 5, 6, 9 & 10 OG - 2	BAF /020	Q&P RR (Q&P RR / 05)	**RISK** Increase in avoidable attendance at A&E from care homes **CAUSE** Failure to support action plan **IMPACT** More pressure on A&E performance	3	Commissioned Enabling service- • LPT Provider for training and education for care home staff, building positive working relationships with GPs and health and social care. • Medicine Optimisation via the CCG Pharmacist Leads, • GP Community Based Contract and weekly ward rounds for proactive and anticipatory care. • Direct referral to the CCG Home Visiting Service and ECPs. Collaborative working with LCC to drive the behaviour change and service improvements. • Development and dissemination of the Admissions avoidance pack for ALL care homes- with follow up to managers to ensure information is understood and services accessed.	• Monitored via the LLR Care Homes Quality Assurance Group led by ELRCCG •A&E Improvement group overseeing actions to monitor and improve admission avoidance process, included in AEDB High Impact Action Plan	4	12	•Reduce the risk by ensuring actions undertaken as per the LLR AEDB and A&E Improvement Group, working with the CCG Programme leads to reduce emergency admissions • LLR Care Home Quality Assurance Group is considering the process for identification, review and subsequent action including the development of a Care Home dashboard to monitor care home A&E attendances. • Current CCG review of Care Home Community Based Service.	Influence	Yasmin Sidyot Interim Director of Urgent & Emergency Care	01-Apr-19
SO - 3, 4 & 8 OG - 1, 2, 3 & 4	BAF080	Q&P RR / EMAS 02	**RISK** Failure to meet ARP standards **CAUSE** Increase in demand/ EMAS unable to recruit to planned workforce levels **IMPACT** Patients don't receive a timely response	4	• Following contract negotiations and NHSE mediation it has been agreed that EMAS will meet ARP standrads by April 2019. A performance trajectory has been agree which sets quarterly targets • EMAS developing workforce plan, require addional staff in order to meet standards •Rota changes being implemented • Ratio mix between DCA and FRV underway • GP urgent tier in place	• Performance discussed at monthly contract meetings but will also be monitored via the partnership board due to payment structure agreed against standards. •PPAG receive monthly updates via exception reporting EMAS were performing reasonably well on the 90 percentile but less well on the average wait time, and better on the 3rd and 4th categories.	5	20	• Continued monitoring of initiatives and perfromnace trajectories	Influence	Yasmin Sidyot Interim Director of Urgent & Emergency Care	01-Apr-19
SO - 3, 4 & 8 OG - 1, 2, 3 & 4	BAF077	Q&P RR / EMAS 03	**RISK** EMAS - A high number of prolonged waits were identified in December 2017 as causes for SI's; prompting Co-ordinating Commissioners to initiate review under GC8. **IMPACT** Potential harm to patients **CAUSE** Delay in response times , handover delays	5	•Monitoring of ARP standards to identify prolonged waits •Routine reporting of SI and incidents with sign off at regional level following LLR review •Urgent Care Tier in place • Workforce plan in place to increase clinical staff numbers	• LLR monthly Contract meetings to discuss performance and escalation to Partnership board if required • Quarterly regional QAG meetings • AEDB • PPAG receive monthly updates by exception	4	16	•Monitor delivery of Quality Improvement Plan (including workforce) at both Regional and LLR level through the agreed meeting structure and assurance groups • Hardwick co-commissioning CCG issued a GC8 notice to EMAS to undertaken a prolonged waits review - Deep dive into CMP4 presented at June 2018 QAG Bi-annual prolonged wait reviews for Cat 1 and Cat 2 did not identify any definitive harm as a result of prolonged wait. System learning to be presented at IUEC group. • LLR specific SI peer review meeting took place in September 2018 which identified further learning for EMAS and other system partners and will be shared at IUEC committee. • Introduction of an STP CQUIN to incentivise safe non-conveyance for elderly frail patients and to identify alternative community pathways	Influence	Yasmin Sidyot Interim Director of Urgent & Emergency Care	01-Apr-19
SO - 3, 4 & 8 OG - 2 & 3	BAF078	Q&P RR / TASL 01	RISK Patient safety – TASL Transport not arriving or arriving late, resulting in missed appointments, impacts on DTOC, patients missing care packages, rebeds, etc. IMPACT Poor patient experience, potential harm to patients and a reputational impact on the CCG CAUSE Ineffective dispatch and planning processes.	4	• Monthly Improvement task and finish group in place reviewing KPI's, Eligibility and discharge flow. • Monthly contract meetings. • Daily activity data being received and analysed by commissioners.	• Monthly CCM • Quarterly CQRG • Ad Hoc Quality Visits • Renal Quality meetings as required • Report to CCB to give further update on improvement. • Monthly Improvement task and finish group	3	12	• Contingency plan developed • CCG meeting with regional commissioners • Monthly updates to NHSE • Monthly Improvement task and finish group • CQC Report 'Requires Improvement', increased oversight NHSE/I & CCG's update to QSF • Improvement Plans in place and monitored by NHSI/CCGsQuality visits undertaken	Influence	Carole Ribbins Interim Chief Nurse and Quality Lead	01-Sep-19

Strategic Objectives (1-10) Organisational Goals (1-4)	Risk Ref.	Source	Risk Description	Risk Score: Impact	Existing Actions/Controls	Monitoring Mechanisms	Risk scores: Likelihood	Risk scores: Rating	Next steps	Risk Treatment	Exec Owner	Last Revised
SO - 3, 4 & 8 OG - 2	BAF/079	Q&P RR / TASL 04	**RISK** TASL fail to provide quality reports in line with the quality schedule and contract monitoring **IMPACT** Lack of quality assurance of service provision **CAUSE** Ineffective reporting systems / databases to capture required data	4	• A Contract Performance Notice was issued on 5th January 2018. Commissioners met with TASL to discuss this further on 18th January 2018 and a comprehensive organisational action plan was produced to encompass the actions required. • Monthly meetings taking place to monitor progress against the action plan.	• Monthly CCM • Quarterly CQRG • Ad Hoc Quality Visits • Monthly NHS E Risk Review meeting with Lincoln and Northants • Renal Quality meetings as required • Report to CCB to give further update on improvement. .	3	12	• Collaboration with Lincoln and Northants CCG for joint Quarterly CQRG meetings • Escalations of CPN as continued failure to submit required evidence • Continued support and discussion re requirements of quality reporting • Process in place & being monitored closely, however, overarching CQC report 'Requires Improvement. See BAF risk 078	Influence	Carole Ribbins Interim Chief Nurse and Quality Lead	01-Sep-19
SO - 3, 5, 8 & 9 OG - 3	BAF/039	F&P (FP/RR/3)	**RISK:** Failure to assure in year local health economy financial viability **CAUSE:** Concern regarding UHL's potential financial performance **IMPACT:** The threat of negative impact on the CCG's finances or that UHL's financial performance renders them unviable	4	Monthly triangulation meetings between contract teams followed by Commissioner update meetings. 5 Year economy Financial Gap has been updated Contracts agreed for 19/20 Financial plans finalised (albeit with a net risk position of £11m for LLR)	City CCG CFO regular informal meetings with UHL Director of Finance to discuss financial performance, risks etc. Provider monitoring of financial performance including delivery of cost improvement programmes - monitored by Internal/External Auditors External Financial performance reports are reviewed monthly, e.g Board Reports Internal and External Auditors Review of position takes place at CCB / SLT	4	16	Regular monitoring, improve financial reporting to CFOs and SLT on system financial position - Summer of 2019 NHSE Escalation of STP - Summer of 2019 Endeavour to find additional in-year savings opportunities to close risks within financial plans - Summer of 2019	Influence	Spencer Gay, Chief Financial Officer	01-Jul-19
OG - 3	BAF/081	F&P (FP/RR/28)	**RISK:** Providers failing to supply service due to errors in reprocurement processes **CAUSE:** Failure of officers to follow the current procurement rules; lack of communication between MAL CSU and CCG staff **IMPACT:** Adverse financial impact, increased timeframes for implementation and organisational reputation; possible legal challenge from bidders	3	• Procurements reviewed by Competition and Procurement Panel to recommend method of procurement • AQP & Tenders run by GEM procurement team to ensure consistancy and compliance Training in procurement arranged for CCG staff. • Procurement strategy approved by Board • Review of procurement work schedule to ensure services approaching procurement deadlines are being fully assessed for VfM etc prior to reprocurement commencing.	• CPC • Procurement updates to be provided to Finance & Planning Committee quarterly • Procurement service specifications reviewed	4	12	• Procurement rules in the Detailed Financial Policies to be reviewed and amended if required - current requirements may not be sufficiently rubust • Board member training proposed for a future development session Procurement outcomes to be published on CCG website. • Head of Financial Accounting reviewing procurement service specs from MAL CSU and LPT and to amend if necessary to ensure adequate services are being received	Control	Spencer Gay, Chief Financial Officer	01-Jul-19
OG - 3	BAF /001	F&P (FP/RR/29)	**RISK** Failure to assure local health economy financial viability over the next 5 years **CAUSE** Lack off robust information and tested schemes **IMPACT** Organisational reputation and possible financial penalties and closer scrutiny	4	• BCT programme established. • SOC agreed and submitted to TDA / NHS England. • PCBC approved by governing bodies during 2016/17. Update issued July 18 • Increased understanding of financial and activity position via trianglation meetings • Updating financial model for STP - July 18.	• Senior Leadership Team • CFO / DF meetings monthly •System Sustainability Group established	5	20	LLR financial strategy in development, to be approved by CFOs and SLT in June Refresh of 5 year model and development of long-term plan - Summer/Autumn 2019 Refreshed 5-year model to inclde generation of renewed savings plans over the period	Influence	Spencer Gay, Chief Financial Officer	01-Jul-19
OG - 3	BAF /009	F&P (FP/RR/30)	**RISK** Failure to maintain control of CCG financial position and deliver statutory duty to breakeven over the coming 5 year planning period **CAUSE** Lack of control of expenditure/activity levels and lack of long term focus on possible future events **IMPACT** Funding in future years required to pay back overspends resulting in less resources to spend on service expansion and development	4	• 5 year plan developed 2014, Updated in 2017 STP LLR plan submitted • Closer LLR working to ensure consistancy of approach • Triangulation of activity and capacity taking place accross the STP area	• Finance & Planning Committee for review of plan and monitoring of performance • Board for review of plan and monitoring of performance C • Corporate Management Team (CMT)) monitor QIPP / Disinvestment identification • BCT CFO meetings monitor and challenge BCT QIPP & action plans •Sustainability group to review QIPP / CIPs	4	16	Request for further initiatives on an STP level Schemes to deliver the unidienfied QIPP being worked up with SRO's. potential schemes being reviewed via sustainability group and POG.. STP level reporting being redesigned to give transparancy of position accross LLR Development of new LLR 5 year plan	Control	Spencer Gay, Chief Financial Officer	01-Jul-19
SO - 4 & 9 OG - 3	BAF/062	F&P (FP/RR/33)	**RISK:** Failure to control prescribing spend leading to significant overspends in year **CAUSE:** Increase volume of drugs prescribed and or increase in cost of drugs prescribed **IMPACT:** CCG overspends against its prescribing budget and potentially cannot mitigate this from reserves.	3	• Monitoring expenditure levels on a monthly basis • Using PresQIPP database to compare CCG activity with like cohort of CCGs Budget set after reviewing potential pressure areas • Implemented restrictions on the prescribing of Gluten Free foods and Paracetemol. Full Medicines Optimisation Team are now in post • Budget based on outturn • Eclipse software Implemented across all practices, providing real time data for analysis for the facilitation of medicines safety and QIPP savings • Medicines Optimisation staff working with practices to ensure maximisation of QIPP savings • Maximising the use of rebate schemes to generate income to offset the full cost of drugs - processes in place to identify rebates available and collect rebates due in a timely fashion • Prescibing Team looking at ways of reducing prescribing waste and repeat prescribing • Close monitoring of the monthly Prescibing QIPP performance against the latest prescibing activity reports using the PMO reporting process	• QIPP and financial impact monitored via Finance & Planning Committee Monthly reporting to Prescribing Strategy Group • Regular meetings between the Chief Nurse, Head of Prescribing and CFO to monitor the situation	5	15	Signing up practices to stop third party ordering of prescriptions. Currently a number of practices signed up. Will be implemented from 1/7/19. Third Party Ordering included in the 19/20 Fed QIPP scheme which has been signed off by Federations. SIRO sign up completed - which will enable greater functionality of Eclipse system - linked to SUS. Full implementation now expected Q2 2019/20 Biosimilars (secondary care impact only). Currently working on patient switches following Humira coming off patent. UHL allocated the cheapest alternative drug by NHSE to switch patients to Federation QIPP in place at the start of the the financial year (19/20) - Q1 implementation for the work programme. Dietetic business case signed off - currently out to advert. 1wte Dietician per Federation and 4 x .5wte Asst Dieticians across WL being recruited to. Meds Optimisation in Care Homes - all signed off - awaiting UHL to action.	Control	Spencer Gay Chief Financial Officer	01-Jul-19

Strategic Objectives (1-10) Organisational Goals (1-4)	Risk Ref.	Source	Risk Description	Risk Score	Existing Actions/Controls	Monitoring Mechanisms	Risk scores		Next steps	Risk Treatment	Exec Owner	Last Revised
				Impact			Likelihood	Rating				
OG - 3	BAF/082	F&P (FP/RR/49)	**RISK:** Lack of leadership, capacity and capability across the system to deliver required transformation **CAUSE:** Difficulty to reach decisions across the system (governance) whilst trying to work as a system. Lack of Transformation/project delivery skills in place in CCGs. Duplication of effort **IMPACT:** Reduced delivery against ambitious plans for redesign/transformation	4	• SRO and AO leads identified for each workstream. CCB to be formally constituted as Board sub group. • LLR QAG reqests fast tracking of delivery via exec leads in CCGs • Financial mitigation plans also focus on fast tracking delivery of areas of QIPP.	• Through Senior Leadership Team, CCB, MDs Workstream SRO's monitor progress	3	12	Improvements to governance structures and collaborative working continue Commissioning and Capability Programme being used to improve governance. Cross system review of skills gaps by SROs & teams	Influence	Spencer Gay Chief Financial Officer	01-Jul-19
OG - 3	BAF/085	F&P (FP/RR/51)	**RISK:** Plans not delivering in terms of required performance improvement on key metrics **CAUSE:** A failiure to deliver the key milestones within the 2019/20 Operational/QIPP Business Cases **IMPACT:** Continued failure against KPIs such as Ambulance Handover Delays and A&E Waiting Times; also potentially a financial risk due to requirement to recover performance	3	There are a range of LLR BCT work stream action plans as well as Governance structures to ensure delivery (as well as an escalation of risks- where delivery is not occuring).	Performance monitoring, contract monitoring, PPAG, Board reporting NHS England assurance oversight Bi-weekly reporting on progress to JMT	4	12	Incorporate into monthly review of plans and in plan development for 19/20 Plans to address these concerns feature in development of 19/20 Plan Robust reporting and confirm & challenge processes agreed and are being implemented through the LLR QIPP Assurance Group and PPAG	Influence	Spencer Gay (Simon Pizzey) Chief Financial Officer	01-Jul-19
OG - 3	BAF/086	F&P (FP/RR/53)	**RISK:** Lack of capacity/capability to influence QIPP delivery led by other organisations **CAUSE:** A failure to deliver on LLR wide plans and mobalise key stakeholders **IMPACT:** Schemes impacting on WLCCG patients and financial position are not controlled by WLCCG personnel	3	Regular review of programmes within the LLR BCT work stream governance structures Regular escalation of programmes (where delivery is off track) to the LLR QIPP Assurance Group.	LLR QIPP Assurance Group LLR Planning Operational Group WLCCG PMO Financial Mitigation Plan	4	12	Define and agree processes on STP footprint Understand roles and responsibilities in System processes Work towards scoping and developing LLR-wide practices of monitoring, measurement and assurance provisionMaintain new vigorous apprach to the LLR QIPP Assurance Group	Influence	Spencer Gay (Simon Pizzey) Chief Financial Officer	01-Jul-19
OG - 3	BAF/087	F&P (FP/RR/55)	**RISK:** Failure to deliver LLR-wide contracting, QIPP and service reconfiguration priorities **CAUSE:** An inability to contractualise existing plans and ensure providers deliver key actions **IMPACT:** Non-delivery of strategic objectives	3	Ensure 2019/20 Operational Plan, Commissioning Intentions and QIPP plans are included within the relevant Primary & Secondary care monitoring structures.	CCB LLR Qipp Assurance Group Senior Leadership Team Finance and Planning Committee	4	12	Review of LLR QIPP at monthly MDs' meeting (Spencer Gay) Continue close working of LLR Finance & Planning / Comms teams (Spencer Gay) PMO liaising with Implementation leads throughout the month to identify areas to fast track/escalate Increased focus on delivery in the LLR QAG Slippage from 18/19 features in 19/20 Plan	Influence	Spencer Gay (Simon Pizzey) Chief Financial Officer	01-Jul-19
OG - 3	BAF/084	F&P (FP/RR/68)	**RISK:** Failure to deliver a robust, deliverable, financially balanced Plan for 19/20 **CAUSE**: Underlying deficit b/f from 17/18 along with inability to agree contracts within envelopes **IMPACT:** CCG placed into Turnaround; control assumed by NHS England	4	STP discussions taking place regarding LLR working Financial challenge (net risk) noted at planning stage, equal to unidentified QIPP	WLCCG Board Finance & Planning Committee Senior Leadership Team System Sustainability Group	4	16	Final Plan to be submitted mid-May Contract negotiations are underway Identification of additional QIPP schemes - JMT leads identified to scope opportunities identified by planning team; update on progress by end of May and some quantification of opportunities by mid-June Plan submission.	Influence	Spencer Gay Chief Financial Officer	01-Jul-19
OG - 3	BAF/067	CRR/35	**RISK** Staff morale and productivity **CAUSE** Anxiety of current workload and lack of clarity around future LLR CCG arrangements. including the formation of a single management team across LLR and increased uncertaintity around security of employment **IMPACT** Retention, productivity, sickness issues impacting on capacity to deliver CCG objectives	4	• Staff briefing dates set and regular programme of updates now in place. • Staff health & wellbeing events held - e.g. flu vacination in October 2017 and 2018. • Send regular updates to staff to keep them informed • Monthly workforce dashboard considered by Corporate Management Team (CMT). • Oustanding building/ maintenance issues complete • Staff User Group reviewed Staff Survey 2017 results and have agreed Action Plan previously agreed by the (Corporate Management Team (CMT) • Update on Staff Survey provided to Board April 2018 • Corporate Management Team (CMT) review interim/agency staff usage monthly.	• Corporate Management Team (CMT) • Staff User Group • Staff survey	4	16	• Weekly email update following CMT circulated to all staff on collaborative updates and general update via 'The Brief' (Dave Rowson) - complete • CMT to update their teams regularly to discuss collaboration - ongoing • CMT to review interim staff usage on a monthly basis and HR metrics including sickness and turnover - ongoing • Specific initiatives to improve staff morale and satisfaction being implemented and further developed (Dave Rowson/CT) • 2018 staff survey results communictaed to staff, discussed with Staff User Group and initial actions to be presented to CMT on 4 March 2019 (KC) - complete • Commissioning Capability Programme in place and outputs to inform future changes to structures, governance etc (CTrev) June - Sept 2019 • CCG Organistaional Day being planned for March/April (CT/KC) - Complete and outputs and actions being implemented	Influence	Ket Chudasama Director of Performance & Corporate Affairs	01-Sep-19

Strategic Objectives (1-10) Organisational Goals (1-4)	Risk Ref.	Source	Risk Description	Risk Score	Existing Actions/Controls	Monitoring Mechanisms	Risk scores		Next steps	Risk Treatment	Exec Owner	Last Revised
				Impact			Likelihood	Rating				
SO - 5 & 9 OG - 3	BAF/072	CRR/40	**RISK** Decisons for STP are not made appropriately or in a timely manner resulting in an inability to meet its aims and deliver in 5-year objectives. **CAUSE** Governance framework for BCT/STP and the way in which it works in practice not strong enough to enable collective decision making and implementation of changes **IMPACT** Delays to implementation or risk of challenge	4	• Senior Leadership Team established • STP lead formalised as TS • STP consultation timeline in place - paused pending national funding review • STP comms and engagemet function in place. • CCB ToR agreed by all three CCGs - supporting move to joint committee in 2018. • STP document presented to governing bodies/boards in April 2018. • Board approved Joint Accountable Officer proposal 12 June 2018 - however more work required (see Next Steps) • Board received update on STP/BCT 12th June 2018. • BCT Next Steps document published August 2018 • CCGs constitution amended to create CCB as formal joint committee.	• Review of Senior Leadership Team agenda by corporate leads in LLR • CCG GB • Review of Senior Leadership Team agenda and papers	3	12	• Proposal for a single joint accountable officer and subsequent management Team across LLR presented to Boards and approved in Dec 2018 - complete • Proposals on STP governance , Terms of Reference and Partnership Group to be discussed at SLT on 21 Feb (CT) • Developing ICS Workshop took place on 16th May • ICS plan to be developed and submitted to NHSE/I • CCG collaboration and configuration options being discussed by GB in Sept	Influence	Director of Performance & Corporate Affairs Ket Chudasama	01-Sep-19
SO - 5 OG - 3 & 4	BAF/068	CRR/52	**RISK** As a result of failure to jointly agree future collaborative working arrangements, future and present collaborative working is delayed/fails to deliver its objectives **CAUSE** Failure to agree a clear collabortative future and unclear governance and lengthy decision making processes **IMPACT** CCG fails to deliver upon its objectives	4	• CCB commenced as a formal joint committee in April 2018	• Corporate Management Team (CMT) • CCB • Senior Leadership Team • QAG • JMT	3	12	• Commissioning Capability Programme in place and outputs to inform future changes to structures, governance - complete • Proposed changes to collaborative governance arrangements (i.e. statutory policies, Conflicts Policy) to be discussed by GB in July, Aug for approval in Sept 2019 • Implementation in Oct 2019 • Include PIC agenda and papers within CoISP review - Aug 2019 • Discussions regarding organisational form & function underway across 3 CCGs • OD Plan for CCG Governing Bodies • Transition Group ToR to go to Aug Board • Engagement re OD planned 20.08.19	Influence	Interim Accountable Officer Caroline Trevithick	01-Sep-19
SO - 3 & 8 OG - 2	BAF /047	CRR/55	**RISK** The provider at Hinckley District Hospital (Alliance) has flagged a risk of cross infection in the endoscopy decontamination department **CAUSE** • Lack of flow between dirty and clean scopes • The fabric of the building does not allow for the necessary alterations to address this and as a result there is a risk to patients and the hospital being able to meet JAG compliance. **IMPACT** Closure of Hinckley & District Hospital with patient activity moved elsewhere (ie. acute providers, other Alliance sites)	4	• Staffing operating policies and procedures in place to ensure 'workarounds' appropriate to the building • (Clinical risk expected to increase year on year) NOTE – likelihood will not reduce with these actions – over time the risks will increase) • Continued implementation of staff operating policies and procedures • Monitoring of infection control by Alliance • The risk is being managed by the provider, but the CCG must consider whether it wants to continue carrying this risk. There are also other health and safety issues due to the estates which are being managed by the provider. The SOC has been agreed for solving this and strategy agreed by CCG and NHSE. Fundng approved in principle by NHSE/I • Repair to X-ray machine undertaken	• CCG Board • Hinckley Hospitals Project Board • BCT reporting into Estates Group • Alliance Management Board • Additional support from Community Ventures Ltd regarding PCB	4	16	• Refreshed of business case - to be approved in May 2019 • Public consultation in Summer 2019 • Outlines business case appraisal - end of 2019 • Link with NHSE for clarity around funding floed from NHSE perspective • Attendance at Hinckley Dsitrict OSC • Next steps - reporting assurances into Project Board	Influence	Chief Financial Officer Spencer Gay	01-Jun-19
OG - 3 & 4	BAF/069	CRR/61	**RISK:** Delay in recruiting to a single AO and single executive team **CAUSE:** CCGs and member practices do not agree on key decisions on process, timescales or approach **IMPACT:** Increased anxeity for affected staff, staff choose to leave.	4	• Joint Executive Steering Group established • Secure HR support from CSU • Paper presented to April, June and July 2018 Board meetings for approach and principles and decision - included indications on engagement with member practices and statutory partners (see Next Steps) • Interim support commissioned to facilitate process with CCGs	• Joint Executive Steering Group/Transition Group • CCG Governing Body	3	12	• Proposal for a single joint accountable officer and subsequent management Team across LLR presented to Boards and approved in Dec 2018 - complete • Recruitment process for single AO complete • Proposals for formal collaborative working to be discussed with practices during Sept - Nov (CT) • Executive team structure being developed and discussed by Transition Group - Aug-Dec • Chairs confirming arrangement within NHSE/I	Influence	Director of Performance & Corporate Affairs Ket Chudasama	01-Sep-19
SO - 3, 4 & 8 OG - 2 & 3	BAF/088	CRR/65	**RISK:** Patient safety and experience could be compromised **CAUSE:** Concerns with TASL's operational performance, quality monitoring systems and long term financial sustainability. TASL were rated as 'inadequate' by the CQC in all domains except 'caring'. **IMPACT:** Risk may lead to patient safety breaches and a negative patient experience. This could result in a loss of a patient trust and could impact the reputation of the LLR CCGs.	4	• CQC published inspection report on 13/02/2019 outlining concerns following visit in October 2018. TASL has challenged the reports findings as well as the process of the inspection. Action plan has been in place since November 2018. • WLCCG as contract host undertook a quality visit on 07/01/2019 to the two sites in LLR with some themes identified and areas for improvement, but no major concerns or risks reported or escalated. • CPM (LLR) for failing to provide quality reports removed/satisfied in November 2018 and lifted. • General Manager appointed by TASL. • TASL has recruited an additional 14 WTE call handlers which has improved performance. • TASL has linked with Leicester College to recruit apprentices. • Contingency plan refreshed with walk through exercise to identify issues/concerns. • Challenge letters relating to under activity sent to providers on a monthly basis. • CQC action plan • LLR incident control centre framework established to ensure contingency for effective management of complexities in the event provider performance reduces below minimum standard.	• Bi-Weekly Interface meetings between WLCCG, TASL, UHL and LPT. • Renal meetings with UHL and TASL as required. • Weekly regional commissioner teleconferences. • Quarterly Commissioner Meetings with Lincolnshire and Northamptonshire. • Monthly contract and quality meetings with TASL. • Daily sitrep reports submitted for call centre activity. • Additional support to the CQC action plan as well as providing the oversight to the operational plans. • NHSE Risk summit meetings. • NHSE Oversight Group established. • UEC Director and TASL CEO fortnightly teleconferences.	4	16	• Formal contingency plan in place, with support accessible from some 3rd party providers. • Monitoring plan to enable effect service provision and appropriate TASL capacity to meet increased demand and pace of UHL and LPT patient discharges as part of winter planning. • UEC Director focus to ensure equity in treatment of provider. • Contractual levers being used – to date 2 contract performance notices issued and being monitored. Both have sparked improvement. • Issues addressed in monthly contract and performance meetings. • Reporting part of monthly/quarterly quality submissions, reviewed monthly and discussed at contract performance meeting. • Updates received monthly transport improvement group meetings. • Regular meetings with quality team to improve standard of information being submitted.	Influence	Interim Director of Urgent & Emergency Care Yasmin Sidyot	01-Sep-19

Strategic Objectives (1-10) Organisational Goals (1-4)	Risk Ref.	Source	Risk Description	Risk Score	Existing Actions/Controls	Monitoring Mechanisms	Risk scores		Next steps	Risk Treatment	Exec Owner	Last Revised
				Impact			Likelihood	Rating				
OG - 1 & 2	BAF/071	LLR IG RR/15	**Risk** There is a risk to the confidentiality of pcd, to the availability of all systems and services, and to the provision of health ervices, due to the increasing threat profile of cyber crime and events including and in particular, where these may be zero day attacks. **Cause** Cyber Attack **Impact** CCG operations compromised and/or patient data breeched.	4	• Secure coding • Peer review of architecture/ data routing • Security/penetration testing • Information content review/ Publication procedures/ Internet and e-Communications Policy	• IGOG • LHIS Security report	4	16	• CCG: Evaluate all web sites that are operated or are associated with the CCG to identify the risk profile of these sites in the context of malicious attack or unauthorised information disclosure. Action the reports to ensure that vulnerabilities are closed - Reports commissioned from 360 assurance. Evidence that actions are completed required - July 2018. • LHIS regular technical review of the local network environment and action plan for cyber security improvement/ maintenance. • CCG: Institute testing and awareness programme to raise user awareness and vigilance with regard to malware and phishing events • LHIS Test plans and walkthroughs to include identification, control and recovery from successful cyber attack including hacking, malware/ virus/ ransomware/ denial of service attacks. • CCG plans to include cyber attack.	Influence	Director of Performance & Corporate Affairs Ket Chudasama	02-Jul-18
	BAF/089	FPRR/69	**NEW** **RISK:** Failure to maintain control of CCG financial position and deliver statutory duty to break even in 19/20 **CAUSE:** Increasing activity levels and failure of QIPP to deliver required savings **IMPACT:** Intervention by NHS England and closer scrutiny alongside loss of reputation	4	Organisational responsibility and accountability through delegated budget management Monitoring of MAL SLA to ensure CSU provide appropriate finance support Further improvement to internal financial reporting to include financial accounting metrics and detailed management accounting reports for each area Best / worst / likely position created and reviewed each month Review of underlying position to ensure sustainability into future years as part of the planning cycle. BCF position being monitored	Budgetary Control (eg Financial Plan aligned to allocations and detailed budgetary reporting) Budget Holder Meetings Detailed report to Finance and Planning Committee Summary report to CCG Board CCG Assurance Checkpoint meetings with Area Team QIPP Assurance Group monitoring in-year QIPP delivery fortnightly Finance Recovery Group chaired by AO reviewing position	4	16	Cross LLR working to reduice risk and understand position. New QIPP schemes being scoped to cover increased risk and unidentifed QIPP within plan	Control	Chief Financial Officer Spencer Gay/	01-Jul-19
	BAF/090	FPRR/70	**NEW** **RISK:** Failure to deliver planned levels of QIPP savings in 19/20 **CAUSE:** Poorly thought through schemes and non-performance of activities related to those schemes due to lack of resources (including workforce) **IMPACT:** Financial balance is compromised due to savings underachieved, Service	3	QIPP schemes have been developed across a range of areas (eg Emergency Admissions, Continuing Healthcare, OP referrals and Prescribing). Leads shared across CCG's QIPP schemes in line with key workstreams in CCG plan Monthly monitoring process in place to review performance of all schemes LLR QIPP meetings in place on a fortnightly basis QIPP actuals and outcomes reconciled with financial position	Finance and Planning Committee Included in Finance Summary report to CCG Board Reported to CCB CCG Assurance Checkpoint meeting with Area Team Internal Audit Reports Confirm and Challenge meetings occuring via PMO for all programmes PMO scrutiny of detailed project plans	5	15	New schemes being worked up with SRO's to cover unidentified QIPP Work ongoing with providers to contractualise identified QIPP	Control	Chief Financial Officer Spencer Gay/	01-Jul-19
Insert lines above here for new risks (this line shouldn't print)												

Patients, Practices, Partners

NHS
West Leicestershire
Clinical Commissioning Group

POLICY DOCUMENT

RISK MANAGEMENT STRATEGY & POLICY 2018-20

Version:	1.1
Ratified by:	Governing Body
Date ratified:	
Name of originator/author:	Louise Guss, Interim Head of Corporate Governance
Name of responsible committee/individual:	Ket Chudasama, Director of Performance and Corporate Affairs
Date of issue:	
Review date:	October 2020
Target audience:	All Staff

All policies can be provided in large print or Braille, if requested. Interpreting services are also available for individuals of different nationalities.

CONTENTS

1 Policy Statement

1.1 This document combines the strategy, processes for managing strategic and operational risks at West Leicestershire Clinical Commissioning Group (WLCCG).

1.2 WLCCG attaches great importance to the effective management of risks that may be faced by patients, members of the public, staff, partners and other stakeholders, and by the CCG itself.

1.3 The quality of care delivered and the safety of patients are vital elements in the philosophy and culture of the CCG, which are embodied in its leadership and its staff. Ensuring risks are managed effectively, consistently and systematically must be an integral part of everyday practice throughout the organisation.

1.4 It is imperative that a culture of transparency and honest reporting is promoted and upheld throughout the CCG to ensure risks are properly identified, evaluated, documented and, most importantly, managed.

1.5 To support the development of a proactive risk management approach across the organisation, the CCG is committed to:

- Embedding effective organisational governance arrangements that respond to strategic change, secure a safe and positive experience for patients, and support high quality and effective service delivery
- Ensuring accountability and responsibility by leading and supporting clinicians and staff
- Identifying levels of 'risk appetite', i.e. definition of the level of risk the CCG is prepared to accept in pursuit of its objectives, and appreciation that this level will vary dependent on the specific risk

2 Aims & Objectives

2.1 The purpose of this document (the Strategy) is to provide guidance to all staff on the management of strategic and operational risks within the organisation. It aims to:

- Set out the risk management process, including how strategic and operational risks are identified;
- Describe the processes used to identify, analyse, evaluate and control risks to the delivery of the CCG's objectives.

2.2 The objectives of WLCCG's risk management policy are to:

- Minimise the chances of adverse incidents, risks and complaints by effective risk identification, prioritisation, treatment and management;
- Maintain a risk management framework, which provides assurance to the Board that strategic and operational risks are being managed effectively;

- Maintain a cohesive approach to corporate governance and effectively manage risk management resources;
- Ensure that risk management is an integral part of the CCG's culture;
- Minimise avoidable financial loss;
- Ensure that WLCCG meets its obligations in respect of health and safety; and
- Enable further development of the CCGs approach to risk management.

2.3 The CCG has a statutory and regulatory obligation to ensure that control systems are in place to minimise the impact of all types of risk which could affect the proper functioning of the organisation.

2.4 The Strategy is also applicable to those risks associated with partnership/collaborative working arrangements and seeks to influence and control partnership risks through agreed management processes.

2.5 The Strategy will be reviewed and updated regularly to reflect the changing role and functions of the CCG and in accordance with appropriate good practice or legislation.

3 Scope of the Policy

3.1 The Risk Management Strategy and Policy covers the management of strategic and operational risks. Strategic risks are significant risks that have the potential to impact across the organisation and are raised and monitored by the executive team and the CCG Board. Operational risks are key risks that impact on individual programme areas and are managed through sub-group risk registers and senior responsible officers.

3.2 This strategy applies to all employees and premises of WLCCG, including any persons/contractors engaged in business (for and on behalf of WLCCG), its activities and functions, including both clinical and non-clinical risks, information and financial risks.

3.3 It primarily relates to the resources directly managed by WLCCG. However, it is recognised that as some services are provided by other organisations outside the CCG (e.g. local authorities, primary care contractors, other commissioning organisations, hosted and shared services etc.), which act on its behalf, they too are included within this strategy. Risks in these situations will be managed through formal partnership working/contract monitoring.

4 Statutory and NHS Requirements

4.1 There is a legal requirement for all employers to ensure that assessment of health and safety risks to employees, patients, others and the organisation itself are carried out in full and reviewed regularly to maintain their accuracy and validity.

4.2 The CCG's approach to effective risk management is based on the following:

- Workplace (Health, Safety and Welfare) Regulations 1992 (as amended 2002) and the Management of Health and Safety at Work Regulations 1999 require that employers should carry out assessments of the risks created by their operations, which may affect staff and others;
- The Data Protection Act 2018 (General Data Protection Regulations – GDPR) and the Freedom of Information Act (FOIA) 2000 and other legislation requires organisations to comply with rules relating to the handling of information and thus minimising information related risks;
- Corporate Manslaughter and Corporate Homicide Act 2007 highlights the commitment required of senior management to take reasonable steps to protect employees and others who may be affected where risks are created by their operations, the implementation of robust risk management systems is of paramount importance; and
- WLCCG's Corporate Governance Framework (i.e. Standing Orders, Scheme of Reservation and Delegation and Financial Scheme of Delegation).

5 Risk Management Principles

5.1 The Risk Management Strategy and Policy is predicated on the following principles. Changes to these principles may lead to a change in the processes that follow:

- The Board Assurance Framework will also act as the CCG-wide risk register and will be presented in a similar format to other risk registers to enable easy reference and escalation/de-escalation between the two;
- Risks will be described in a systematic and consistent way to ensure that any reasonably informed reader can understand and evaluate the effectiveness and relevance of the rest of the entry on the risk register;
- Risks are things that are yet to happen, but might. Therefore any articulation of risk should use words such as, 'might', 'may' rather than 'will', 'could' rather than 'would';
- Risks are owned by a member of CMT even if they are operationally owned by managers reporting to them;
- Risks will be scored using a 5x5 matrix with Impact scores determined by reference to a matrix (appendix X) based on the format promoted by the National Patient Safety Agency (now part of NHS England);
- Risks can be positive as well as negative; however most of the effort in managing risks will be avoiding or mitigating negative or down-side risks;

- Collaborative risks managed by our partner CCGs will be recorded and captured on the appropriate CCG risk register/BAF 'as is' from the hosts' risk registers. So, although they will be presented in the same format as the other WLCCG risks they will adopt the standards that the relevant host CCG has adopted. This will ensure consistent reporting of these risks across Leicester, Leicestershire and Rutland (LLR) while still maintaining each CCG's right to set out their risks to their own preference;
- Collaborative risks owned by West Leicestershire CCG will be captured first on the appropriate WLCCG risk register which will be updated and used to populate risk registers held by collaborative bodies, such as the Provider Performance Assurance Group (PPAG); and
- Risk scores will always be reported 'net' of existing controls and monitoring arrangements.

6 Risk Management Approach

6.1 Risk and risk taking is inherent in everything the CCG does: determining commissioning priorities, managing a project, purchasing equipment, taking decisions about future strategies, or even deciding not to take any action at all. Therefore, a structured, systematic and consistent approach to risk management, which encompasses all the CCG's functions and activities, has been adopted.

6.2 The resources available for managing risk are finite and so the aim is to achieve an optimum response to risk, prioritised in accordance with an evaluation of the risks and to take action to manage risk in a way, which it can justify to a tolerable level.

6.3 A flow chart is shown at appendix 3 which summarise the stages in the process for managing risks, which are covered in detail in the next section.

7 Stages for Managing Individual Risks

7.1 There are 8 key stages in the CCG's risk management approach;

- Identifying the risk
- Describing the risk
- Scoring the impact of the risk
- Controlling the risk
- Monitoring the controls
- Scoring the likelihood of the risk
- Rating the risk
- Agreeing actions
- Reviewing the risk

7.2 These are described in more detail below and summarised as a flow chart at appendix 3.

Identifying the risk	Risks will be identified in a variety of ways. For example, through intelligence from other CCGs' experiences, formal identification of risks at the start of a major piece of work or learning lessons from events that have happened etc. At this stage the risk owner should also be identified and agreed. This will normally be the member of CMT most closely associated with the risk. It is the risk owner's responsibility to ensure that risks are properly assessed and managed, although in many cases this will be done in practice by one of the CMT member's managers.
Describing the risk	Risks should be described as clearly as possible so that the cause and impact are clearly identified. This will make it easier for later stages of the process. At WLCCG, the format for describing risks is RISK, CAUSE, IMPACT as shown in the example below; **RISK** the CCG may struggle to retain key members of staff **CAUSE** national shortage of relevant skills **IMPACT** key work not getting done OR additional costs incurred engaging interim support
Scoring the impact of the risk	The impact of a risk is rarely affected by any controls and mitigations (most affect the likelihood), so the impact can and should be scored before taking into account any controls or monitoring. The impact of a risk will be scored with reference to the matrix shown at appendix 2 based in what type of risk it is. If the impact of a risk covers more than one element (e.g. finance and injury/harm) then the higher of the two scores will apply. If the seriousness of the impact changes, it is usually as a result of external factors, for example, new sanctions being introduced for non-compliance with a particular function. It is therefore important that the impact score is kept under review and adjusted as necessary, along with the 'impact' element of the risk description.
Controlling the risk	Controls are mechanisms or processes that mitigate the risk. For example, a control against theft is a lock; a control against the risk of losing key staff is a retention policy. Often, controls will mitigate the likelihood (not the impact) of the risk. Only the key controls should be captured in the risk register, so for authors and readers, it should be clear that each control relates to the risk as described. If not, then additional controls may be needed, superfluous ones can be removed from the register or it may be that the risk has not been described correctly.

By definition, a control is something that already exists – a plan to implement a control is not a control, it's an action.

Monitoring the controls

Controls need to be tested and monitored to ensure they are effective. This stage should identify how the controls identified in the previous stage are being monitored, either actively (e.g. through a regular item on a meeting agenda) or by exception (e.g. the reporting of a breach).

In other organisations, this stage may be described as 'sources of assurance'.

It is important that in describing a monitoring activity such as a meeting or process that there is confidence that the activity is actually is monitoring the control. This can be checked by reference to meeting agendas or minutes, speaking to people involved etc.

Scoring the likelihood of the risk

Once the controls and monitoring arrangements have been identified, then the likelihood score can be determined taking into account those controls (elsewhere this is called the 'net' score). Scoring is done using the simple table, shown below.

LIKELIHOOD	
1	RARE
2	UNLIKELY
3	POSSIBLE
4	LIKELY
5	ALMOST CERTAIN

In determining the likelihood, a degree of judgement must be used, taking in to account factors such as;

- If the risk has happened previously (if not, then it is unlikely to have a high score),
- How imminent it is (e.g. if something is almost certain to happen in 5 years' time, then giving a high score now may be misleading.)
- A high score implies that the current controls are inadequate so a 'sense check' should be done to see if other controls are in place but have not yet been captured

Rating the risk

Rating the risk gives a view as to the overall importance of managing the risk and helps to prioritise those that need most attention.

The overall rating of the risk is calculated by multiplying the impact and likelihood scores and resulting score is classified by reference to the table at appendix 2 and summarised in the table below:

IMPACT						
	5	5	10	15	20	25
	4	4	8	12	16	20
	3	3	6	9	12	15
	2	2	4	6	8	10
	1	1	2	3	4	5
		1	2	3	4	5
	LIKELIHOOD					

There is a ‘sense check’ needed once a risk rating has been done to compare the rating to that of the other risks on the risk register to determine if it is proportionate to other risks.

Agreeing actions

If the rating of the risk is too high, then actions should be identified and taken to improve the controls or monitoring and reduce the likelihood of the risk occurring (or occasionally the impact of the risk).

Initially the risk owner will need to determine if the risk is too high and this will be confirmed or challenged by the relevant sub-group. Assessing whether a risk rating is too high may sometimes be done by reference to a pre-determined ‘risk appetite’.

In setting actions, it should be clear ‘who’ is going to do ‘what’ by ‘when’. Identifying the ‘what’ without a clear idea of who is going to do it or a target date by when it should be done will not give confidence that the action will be achieved. If the action isn’t precise enough, then the first action is to achieve that level of precision, for example the action might be ‘By <when>, risk owner to find individual to implement <what>.”

Once actions are complete they will be removed and may be added to the ‘controls’ or ‘monitoring’ section of the risk register as appropriate at which point the risk should be re-rated to see what impact the actions have had on the overall rating of the risk.

Reviewing the risk

Risks should be reviewed regularly, especially to determine if external factors have changed and to check that agreed actions have been implemented. Keeping track of when a risk was last reviewed will give confidence to the Board or relevant sub-group that risks are being actively

managed and not just being entered on to a register as a 'back covering' exercise.

7.3 The method of documentation used by the CCG is a risk register template (and a similar template for the Board Assurance Framework) which, if not already being used can be obtained from the Corporate Affairs Team.

7.4 It is good risk management practice for all levels of the organisation to undertake risk assessments appropriate to their areas of responsibility. Formal risk reporting is at sub-group level (including CMT) and above. Risks of all types are assessed and managed in accordance with this Strategy and any additional guidance circulated by or on behalf of the Assistant Director Corporate Affairs.

8 Board Assurance Framework (BAF)

8.1 A two-tier process involving the risk registers and the BAF has been implemented. The aim of the two tier approach is to ensure that the bigger strategic picture does not become clouded by day to day risk management issues.

8.2 A threshold for escalating risks to the BAF has been set using the 5 x 5 risk rating matrix, whereby any risk that has an inherent/net risk score of 15~~2~~ or above must be reported on the BAF; however, any risk that has an inherent/net risk score of 12 is discussed with the Director of Performance & Corporate Affairs and the relevant Committee Chair to establish whether there is a case for the risk to be escalated to the BAF.~~.~~ ~~However, this should be discussed with the Corporate Management Team initially to establish whether there is a case for the risk to be escalated to the BAF even if the rating is below 12.~~

8.3 When risks are escalated to the BAF, they still remain on the relevant risk register. This ensures more detailed scrutiny and management by people closer to the issue.

8.4 The CCG Board will receive the BAF on a quarterly basis along with an accompanying report. The Audit Committee will receive either the BAF or one of the risk registers at each meeting to review and ensure that the risk management process is operating effectively.

8.5 The flow chart at appendix 2 shows the risk management process and the inter-relationship between risk registers and the BAF.

9 Collaborative Risks

9.1 The major health contracts are managed collaboratively across LLR through bodies such as the Provider Performance Assurance Group (PPAG) and the Urgent Care Board (UCB), which have their own risk registers. The risks on these registers should mirror those held by the CCGs and there should be no risks on the collaborative registers that do not appear on CCG registers.

9.2 Collaborative risks should have been captured initially by the CCG responsible for managing the contract and then reported to the relevant

collaborative body, along with regular updates. The other LLR CCGs will be able to use this information to update the relevant risks on their risk registers.

9.3 Occasionally, risks may be identified or adjusted at the collaborative meeting, which should then be reflected in the CCG registers.

9.4 The flow chart at appendix 3 shows the relationship between the CCG's risk registers and BAF and the collaborative risk registers.

9.5 It should be noted that the risks being managed by providers would not be treated as collaborative risks, as they are not managing risks on the CCG's behalf. There may be, however, reference to provider controls and actions in the CCGs' risk registers or collaborative risk registers.

9.6 The CCG will work with the collaborative governance bodies, including the Collaborative Commissioning Board and the Provider Performance Assurance Group to support their consideration and management of collaborative risks to the LLR and ensure any risks or actions are identified and escalated to the relevant collaborative body or local CCG as appropriate.

10 Responsibilities

10.1 The **CCG Board** has a duty to assure itself that the organisation has properly identified the risks it faces, and that it has processes and controls in place to mitigate those risks by:

- Monitoring the strategic risks on an ongoing basis via the BAF;
- Receiving assurance in relation to the risks from the sub-groups and the Audit Committee;
- Approving and reviewing strategies for the management of risk;
- Demonstrating leadership, active involvement and support for risk management; and
- Actively monitoring risks and the implementation of internal controls to manage the risks through its sub-groups and CMT.

10.2 The **Audit Committee** is responsible for:

- Reviewing and ensuring that the CCG has established and is maintaining a robust and effective system of integrated governance, risk management and internal control across all areas of its business;
- Ensuring that there are appropriate and adequate links between risk management, financial risk, corporate and clinical governance;
- Obtaining sufficient assurance to enable the Annual Governance Statement to be signed off by the Managing Director by preparing an annual summary report;
- Reviewing the BAF on a quarterly basis to provide assurance to the CCG Board that the organisation's risk management processes are effective and risks are being properly controlled;

- Reviewing results of audit work completed on the risk management system and organisational performance;
- Approving the annual audit plans for internal audit and external audit, which are based on the organisation's BAF and risk registers.

10.3 The CCG Committees of the Board are responsible for:

- Ensuring that risks arising through their work are reported to the Board, as necessary, in line with this Strategy and that risks are monitored and managed through their relevant meetings;
- To review the effectiveness of the controls in place for each risk on the committee/sub-group risk register.

10.4 In designing the respective terms of reference for each Committee, consideration has been given to establishing appropriate risk management processes and corresponding accountability arrangements. Terms of reference for the Committees are subject to continuous review and assessment to focus their work on the effective achievement of the key organisation objectives.

10.5 The **Corporate Management Team** (CMT) (i.e. the CCGs most senior managers) are responsible for:

- Reviewing the Corporate Risk Register on a quarterly basis in order to ensure effective risk management of these risks and to escalate to the BAF where appropriate;
- Reviewing the BAF before it is reported to the Board;
- Establishing effective links, which enable lessons learned from the risk process to be directly fed into the business planning cycle;
- Ensuring effective risk management processes are in place within their teams, within their scope of responsibilities and in line with CCG policy;
- Communicating risks within their teams to all members of staff within their remit;
- Ensuring that all staff receive appropriate information, instructions and training to enable them to work safely.

10.6 In respect of information assets, the CMT and their direct reports are also required to assist the Senior Information Risk Officer (SIRO) in identifying information assets in their work areas, and nominating an Information Asset Owner to undertake and submit risk assessments (and action plans) to the SIRO upon request.

10.7 The **Managing Director** is the accountable officer for WLCCG and, as such, has overall accountability and responsibility for:

- Meeting statutory requirements;

- Adhering to guidance issued by the Department of Health in respect of risk and governance (e.g. Annual Governance Statement); and
- Ensuring that there is an effective risk management system in place within the CCG and that all personnel with risk management responsibility are appropriately trained.

10.8 The **Director of Performance and Corporate Affairs** has delegated responsibility from the Managing Director for:

- Managing the strategic development and implementation of organisational risk management systems and processes;
- Corporate and information governance (including health and safety);
- Overseeing the handling and monitoring of incidents, complaints and litigation claims;
- Regularly reporting on the content of the BAF and risk registers to the CCG Board, CMT and Audit Committee;
- Ensuring that there are appropriate internal and external audit reviews of the CCG's risk management process, internal controls and the BAF on an annual basis;
- Providing advice, support and leadership on risk management; and
- Ensuring this policy is reviewed and updated on a regular basis.

10.9 The Director of Performance and Corporate Affairs will also act as a central reference point for all business risk management issues within the CCG by:

- Facilitating and forming risk management processes as an integral part of normal management processes;
- Receiving and collating information on risks within the CCG;
- Monitoring new developments within the management of risk;
- Developing knowledge and expertise, and acting as a liaison point for risk management issues (internally and externally); and
- Monitoring proposed developments and initiatives and checking they are likely to be compliant with good risk management practices.

10.10 The Director of Performance and Corporate Affairs is also nominated and trained as the **Senior Information Risk Owner** (SIRO), with responsibility to act as an advocate for information risk management and information governance issues at CCG Board level. The SIRO will:

- Ensure information risk management is incorporated into the CCG's Risk Management Policy and Strategy and where required, will review and agree actions in respect of identified information risks;

- Take ownership of the risk assessment process for information risk, including a review of an annual information risk assessment to support and inform the Annual Governance Statement; ensuring that WLCCG's approach to information risk is effective in terms of resource, commitment and execution and that this is communicated to all staff; and
- Provide a focal point for the resolution and/or discussion of information risk issues.

10.11 The information risk supporting infrastructure to provide support to the SIRO will consist of the Caldicott Guardian, the Information Security Manager (Health Informatics Service (HIS)) and the Information Governance Officer (Midland and Lancashire Commissioning Support Unit).

10.12 The Chief Nurse and Quality Lead is nominated and trained as the **Caldicott Guardian** (CG), with responsibility for:

- Protecting the confidentiality of patient and service-user information and enabling appropriate information-sharing;
- Representing and championing information governance requirements and issues at Board or CMT level and, where appropriate, at a range of levels within the organisation's overall governance framework; and
- Managing and overseeing the performance management of serious incidents reported by the providers of health services commissioned by the CCG.

10.13 The **Chief Finance Officer** has delegated responsibility for:

- Managing the strategic development and implementation of financial risk management relating to organisational financial performance management;
- Governing the risks within capital planning and estates management; and
- Ensuring robust counter fraud arrangements are in place.

10.14 The **Corporate Affairs Officer** within the Corporate Affairs Team is responsible for:

- The ongoing maintenance and development of all the risk registers and the BAF on a monthly basis; and
- Coordinating responses and producing reports for the Audit Committee and the CCG Board on a regular basis.

10.15 All **managers** are responsible and accountable for the daily management of risks within their areas of responsibility and authorised to undertake risk assessments on a proactive basis.

10.16 All **staff** (including contractors and agency staff) are bound by this strategy by:

- Familiarising themselves with this strategy and risk management processes at the point of induction;
- Identifying risks within their areas of work and reporting these to their line managers;
- Being aware of their duty under legislation to take reasonable care of their own safety and the safety of others and complying with key policies; and
- Attending training and development events as required.

10.17 Where joint working responsibilities exist, WLCCG will ensure that all partner organisations are involved in all appropriate aspects of risk management. Key partners will include NHS England, neighbouring CCG's, acute and other healthcare trusts, police, statutory and voluntary groups (including patient representative groups) etc.

10.18 **Specialist risk management support** will be provided to the Board, CMT, managers and other WLCCG employees as deemed necessary and following discussion and approval by the Director of Performance and Corporate Affairs.

10.19 **Information Asset Owners (IAOs)** are accountable to the SIRO and will provide assurance that information risks are being managed effectively for those information assets that they have been assigned ownership, by:

- Understanding what information is held, in what form, how it is added and removed, who has access and why;
- Approving the level and extent of transfer of data to removable media;
- Ensuring that access rights to information assets are limited to the minimum needed, that usage of information is monitored and best use is made of information assets; and
- Undertaking risk assessment, reduction and prevention for their information assets including ongoing evaluation and risk management. This process includes methods of management, avoidance, mitigation, financing, and/or acceptance of the risk.

11 Implementation and Training

11.1 This Strategy will be made available to all staff via WLCCG's intranet as everyone has a responsibility in risk management.

11.2 The training and development of all staff is an integral part of WLCCG's approach to risk management. An effective implementation of the Strategy requires all staff to be made aware of the WLCCG's approach to risk management, what their role is and the forms of support available to them. This will be achieved through staff induction training and by issuing all staff with a guide to risk management. An annual cycle of updates and learning opportunities will be a core component of the organisational development plan.

11.3 Information governance training provision will also cover aspects of information risk assessment. As part of the staff mandatory training programme it is expected that all staff receive annual basic information governance training, appropriate to their role, through the online NHS Information Governance Training Tool or the Electronic Staff Record (ESR) system.

11.4 All Board members and the CMT will receive risk management awareness training through the Board development sessions and extended CMT development sessions as appropriate.

12 Monitoring / Audit Arrangements

12.1 The risk management process is continually evolving and the systems must be reviewed in the light of changes in the CCG's environment, operations, guidance, best practice and legislation. As a result this Strategy will be reviewed on at least an annual basis by the Director of Performance and Corporate Affairs who will:

- Monitor and review its performance in relation to the management of risk and the continuing suitability and effectiveness of the systems and processes in place to manage risk;
- Monitor and review compliance in relation to this Strategy by using the information it receives from external regulators and internal governance policies, systems and processes (including the effectiveness through the organisational programme of internal audit);
- Ensure the CCG Board signs off the Board Assurance Framework on an annual basis and the Audit Committee approves (on behalf of the Board), the Annual Governance Statement by the Managing Director.

13 Other Considerations/Further developments

13.1 As the maturity of the CCG's risk management systems increases, other factors will be brought into the Strategy. For context, some of these are described below.

POTENTIAL DEVELOPMENT	EXPLANATION
Categories of risk	Understanding the category of a risk (e.g. patient safety, financial, information, performance etc.) helps to assess the impact rating (with reference to appendix 1). Some organisations capture the category on the risk register, although where the risk covers more than one category this can become complicated or lead to risks being duplicated.
Gaps in assurance	As mentioned in the strategy, some organisations describe monitoring as 'sources of assurance' and in addition identify specific gaps in assurance that need to be addressed. It encourages an assessment of the actions needed to address the gaps to improve assurance. For the CCG, these actions

	should be captured in the 'action' column of the risk register or BAF.
Hot spot mapping	The Board Assurance Framework should be developed from the corporate objectives downwards, and using a diagram to show the risk scores of strategic risks relating to individual corporate objectives can give the Board an assessment of whether some objectives are more at risk than others.
Original, current, residual and target ratings	Some organisations separate out the risk scoring at various stages of the risk management lifecycle. The **original** rating will be based on the impact and likelihood scores assuming that no controls were in place. The **current** rating is what the risk is now, taking into account existing controls (this is what the CCG uses at the moment). The **residual** rating is what the score will be once the actions described have been implemented and embedded. The **target** rating (set with reference to the risk appetite) is what the risk rating needs to be before the organisation is content and stops implementing further actions.
Proximity scores	In assessing the likelihood score, consideration should be given to how quickly a likely event occurs. For example, the identification of a funding gap in 5 years' time should not be viewed with the same severity as a funding gap this year. Some organisations use a proximity score to adjust the likelihood score to take account of this point.
Risk appetite	This sets the threshold below which the CCG can be assured that a risk is being adequately managed. Often, risk appetite can be set by the category of risk but in any event if they are used they should be individually reviewed.
Risks vs issues	Many risks are added to the CCG's risk register after an event has occurred. Technically, something that has occurred is not a risk but an issue. The management of issues is and should be different from risk management, as it is about reacting to something that has happened rather than trying to stop something happening. Some organisations (especially in the context of project management) will keep a separate issues log that will have a one dimensional scoring system (only showing impact) and identifying actions that are being taken to address it. Alternatively, they can be captured on the risk register with a likelihood of 5 meaning 'has already happened' and managed alongside other risks. One of the problems with this approach is that there may be confusion about the actions being taken to address the issue and the actions needed to stop it recurring.
Tracking over time	Reporting risks in the risk register or BAF gives much needed detail about how individual risks are being managed, but

	doesn't help to provide a strategic overview of how successful the organisation is being in managing risks over time. Providing a regular report showing the scores of risks over time can help to provide assurance (or otherwise) that risk scores are generally being reduced as the risks are actively managed.
Types of risk treatment	Some risk registers classify the controls and actions based on the '4 Ts'; • Terminate (avoid the risk altogether, for example by not embarking on a risk activity) • Treat (reduce the likelihood) • Transfer (offload the risk elsewhere, for example, taking out insurance) • Tolerate (accept the risk as is, especially in relation to the risk appetite) These are useful prompts to help to identify what else can be done to manage risks and some organisations will flag these on the risk register.

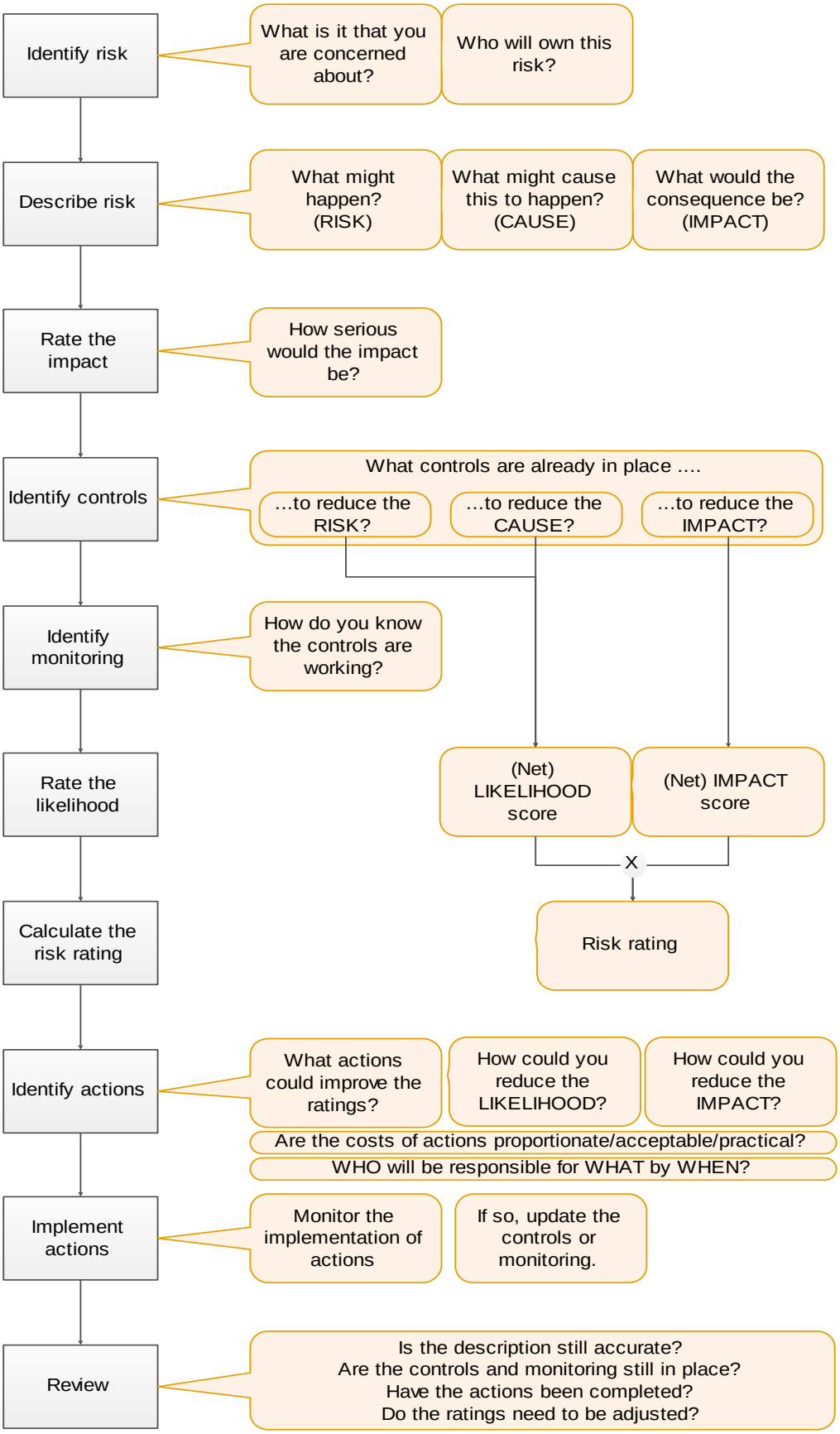
Appendix 1 Risk prioritisation and reporting

Risk Score	Category	Risk priority
1 - 3	Low risk (green)	▪ Acceptable risk, can be managed by routine procedures at a local level; ▪ Periodic monitoring and review to be undertaken at sub-group level to ensure that risk has not escalated and controls are still effective.
4 - 6	Moderate risk (yellow)	▪ Specific responsibility for risk assessment and action planning must be allocated to a named person (manager, clinician); ▪ Usually deadline for completion will be within 6 to 24 months and will depend on resource availability; ▪ Action to eliminate or reduce these risks would normally be the responsibility of the relevant directorate; ▪ Risk and proposed action plan to be reported to the lead officer.
8 - 12	High risk (orange)	▪ Urgent senior management attention required; ▪ Within one month an appropriate action plan must be agreed, usually with a deadline for completion of no more than 6 months; ▪ Action to eliminate or reduce these risks would normally be the responsibility of the relevant directorate; ▪ Progress and monitoring will be at Executive Team level via the Corporate Risk Report; ▪ Risk and proposed remedial action plan to be reported to Audit Committee via reports as per its work programme.
15 - 25	Extreme risk (red)	▪ Immediate action required; ▪ A Chief Officer / Director must be informed and s/he will take responsibility for development and implementation of an appropriate risk action plan and inform the Managing Director; ▪ Risk and proposed action plan to be reported at Board level via the Corporate Risk Report and Assurance Framework updates. ▪ Progress and monitoring will be at Corporate Management Team level with updates to the Board on a monthly basis or at frequency agreed by the Board.

Appendix 2 RISK IMPACT TABLE

IMPACT	1 Insignificant	2 Minor	3 Moderate	4 Major	5 Catastrophic
Service/ business interruption	Interruption in a service, which does not impact in the delivery of patient care or the ability of patient care or the ability to continue to provide the service. Immediate on-site containment.	Short-term disruption to service with minimal impact on patient care. Locally contained situation.	Some disruption to service with unacceptable impact on patient care. Non-permanent loss of ability to provide service. On-site containment with outside assistance	Sustained loss of service which has serious impact on delivery of patient care resulting in major contingency plans being invoked. Regional environmental repercussions.	Permanent loss of core service or facility. Disruption to facility leading to 'knock on' effect across local health economy. National environmental consequences.
Financial Cost/ Loss	<£1,000	>£1,000	>£10,000	>£100,000	>£1,000,000
Patient feedback/ Litigation	Unlikely to cause complaint. Litigation risk is remote	Complaint possible. Litigation unlikely.	Litigation possible but not certain. High potential for complaint.	Litigation expected/certain.	Litigation expected certain. Multiple claimants.
Adverse Publicity/ Reputation	Unlikely to warrant coverage in media. Little effect on public confidence or staff morale.	Local media – short-term Minor effect on staff morale/public attitudes	Local media – long –term. Impact on staff morale and public perception of the CCG.	National media <3 days. Public confidence in organisation undermined. Usage of services affected.	National media>3 days. MP concern (questions in the House)
Quality of the Patient Experience/ Outcome	Unlikely to impact on quality of patient care.	May impact on patient experience – readily resolvable	Mismanagement of patient care, short-term effects (<1 week)	Mismanagement of patient care, short-term effects (>1 week)	Total unsatisfactory patient outcome or experience
Performance Targets	No impact on targets	Insignificant impact on local or national targets	Adverse effect on local or national targets	Failure to meet local or national targets. Will have adverse effect on ratings	Failure to meet statutory obligations. Enforced management of CCG
Patient Safety	No injuries or harm	Short-term injury/illness <3 days sickness	Adverse event which impacts on small number of people. RIDDOR reportable. Long-term sickness Semi-permanent injury/illness.	Permanent injury. Long term adverse effect.	Incident leading to unexpected death or major permanent injury to 1 or more person(s)

Appendix 3 Risk Management Flow Chart and Quick Guide



Appendix 4 Relationships

Risk register(s) – Board Assurance Framework – Collaborative Risk Registers