NHS
West Leicestershire
Clinical Commissioning Group

Paper F

WEST LEICESTERSHIRE CLINICAL COMMISSIONING GROUP
BOARD MEETING

12 November 2019

Title of the report:	Board Assurance Framework Update
Section:	Governance
Report by:	Stuart Fletcher – Head of Corporate Governance / Amy Stevens – Corporate Affairs Officer
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 risks as at 31 October 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. 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.

2. The BAF has been reviewed and updated by the relevant leads to show the latest position as at the 31 October 2019, which is attached in Appendix 1.

3. The total number of risks appearing on the BAF as at 31 October is 24, compared to 31 in September and June 2019. Key changes for Board members to note are detailed in the main report.

4. At the September 2019 meeting, Board members confirmed that they were happy with CCG's revised risk escalation process: any risk that has a net risk score of 15 or above must be reported on the GBAF; risks with a net risk score of 12 or below are reported by exception.

5. This decision was made in order to ensure that the BAF remains focussed on the current strategic risks. As part of this revised approach, a number of 'operational' risks with a net risk score of 12 have been removed from the BAF and these can be found listed in Appendix 2 (also greyed out in this iteration of the BAF).

6. In order to enhance current discussions on the BAF, a table has been included in the main report which maps the current BAF risks against each strategic objective.

RECOMMENDATIONS:

West Leicestershire CCG Board is asked to:

APPROVE the Board Assurance Framework as at 31 October 2019

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

WEST LEICESTERSHIRE CLINICAL COMMISSIONING GROUP
BOARD MEETING

12 November 2019

BOARD ASSURANCE FRAMEWORK

INTRODUCTION

1. The Board Assurance Framework (BAF) has been reviewed and updated and shows the latest position as at 31 October 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 15 or more. In line with the CCG's Risk Management Strategy, the threshold for automatic risk escalation to the BAF is set at a net score of 15 or more, however, the BAF does contain risks with a lower net risk score where the risk is deemed to be strategic. 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 monthly 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 September F&P meeting;
    - PCCC Risk Register at September PCCC meeting;
    - Q&P Risk Register at October Q&P meeting
    - Corporate Risk Register at CMT in October and November
    - Corporate Risk Register at Audit Committee in September.

CURRENT POSITION

3. As at 31 October 2019 there are 15 red rated risks, which is the same number reported in Sepetmber; however, there has been a change to the risk profile. This is outlined further under 'Key changes to note':

Risk ref	Description	Score as at 31 Oct	Change from Sept
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/079 (Q&P RR/TASL 04)	No quality reports have been received to date in line with the quality schedule and contract monitoring	16	
BAF/039 (FP/RR/03)	Failure to assure in year local health economy financial viability	20	
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/047 (CRR/55)	Provider at Hinckley Hospital has flagged risk of cross infection in endoscopy decontamination department	16	
BAF/088 (Q&P RR 06) (Previously CRR/65)	Patient safety and experience could be compromised due to TASL's operational performance, quality monitoring systems and long term financial sustainability	20	
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	
BAF 091 (Q&P LPT/RR/01)	NEW LPT - Patient safety and quality/CQC report published as REQUIRES IMPROVEMENT	16	

RISK COMPARISON – Sept 19

4. The total number of risks appearing on the BAF as at 31 October is 24, compared to 31 in September and June 2019. The current WLCCG BAF risks are comprised of:

Risk score	Number of risks
12	9
15	2
16	9
20	4

KEY CHANGES TO NOTE

5. Board members are asked to note the key changes to the BAF, as listed below.

6. Seven risks have been removed from the BAF and are listed in Appendix 2. The risks will remain on their respective risk registers and will be managed by the Risk Owners accordingly.

7. The following risks have been added to the BAF:

BAF Ref	Risk Description	Net Risk Score
091 (Q&P RR/LPT 01)	NEW Patient safety and quality / CQC report published as REQUIRES IMPROVEMENT	16
092 (CRR/66)	NEW No integrated Care Alliance within the LLR system	12

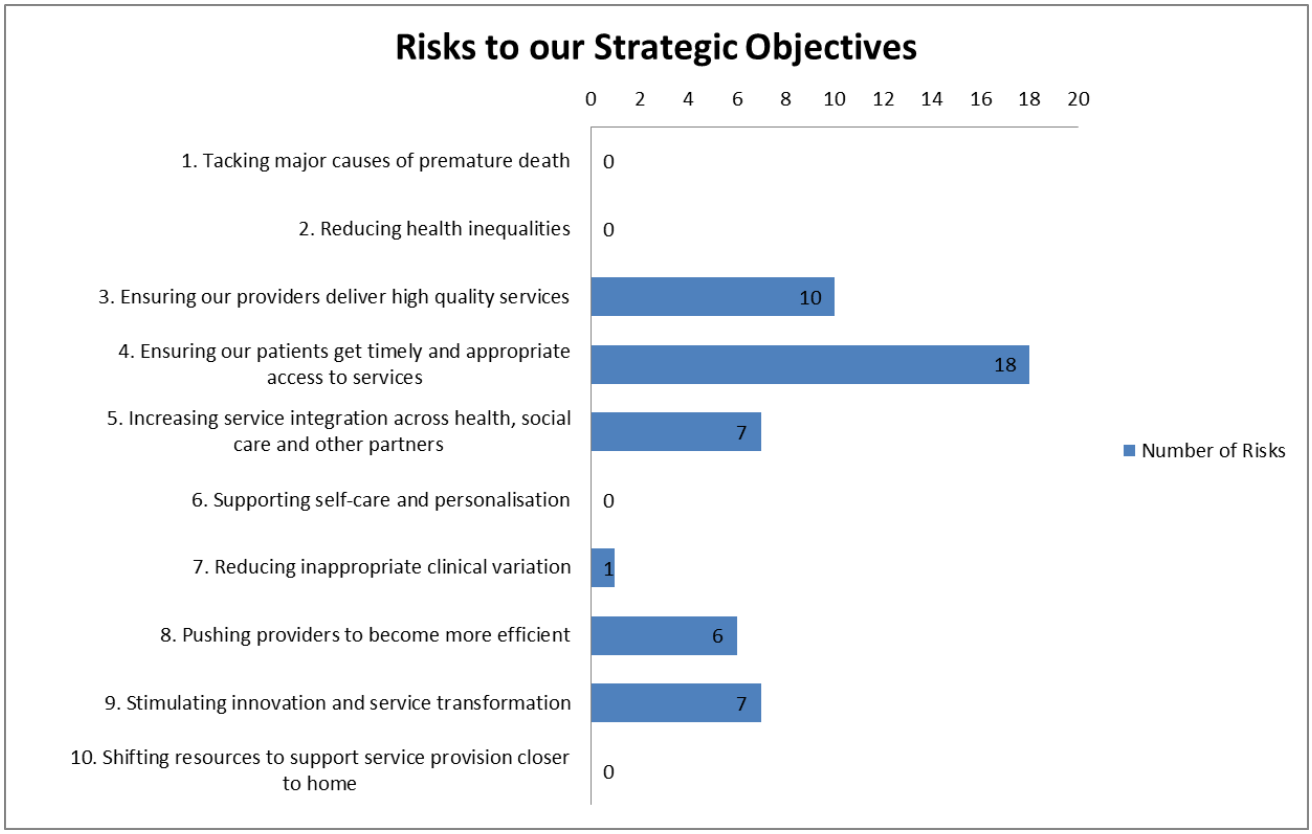
8. The following BAF risks have had a net risk score change but still remain on the BAF:

BAF Ref	Risk Description	Previous BAF Score	New BAF Score
039 (F&P/RR 03)	Failure to assure in year local health economy financial viability	16	20
079 (Q&P RR/TASL 04)	No quality reports have been received to date in line with the quality schedule and contract monitoring	12	16
088 (Q&P RR/TASL06) (previously CRR/65)	TASL - Patient safety and experience could be compromised	16	20

9. Board members are asked to note that BAF risk 088 – TASL patient safety and experience, has been transferred from the Corporate Risk Register to the Quality & Performance Risk Register and has increased from a net risk score of 16 to 20. Board focus will be given to all TASL risks at the next meeting when the Head of Contracts and Provider Performance will be invited to attend to provide a more detailed update.

LINKS TO STRATEGIC OBJECTIVES & GOALS

10. As requested at the last meeting, all BAF risks have been linked to our ten Strategic Objectives and our four Operational Goals. The charts below helps to illustrate which strategic objectives and goals are impacted by our current BAF risks. There is also a column on the BAF which contains this information and which can be referred to for additional detail.



RECOMMENDATIONS:

West Leicestershire CCG Board is asked to:

APPROVE the Board Assurance Framework as at 31 October 2019

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

Appendix 1 - BOARD ASSURANCE FRAMEWORK - October 2019

Ownership			Caroline Trevithick, Interim Accountable Officer			CCG Board					Oct 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 & 7 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	October 2019
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 • Process for collaborative working established (subject to full governance ratification) • LLR Primary Care cOmmissioning Group established & Primary Care Commissioning & Quality Group established	Influence	Ian Potter Director of Primary Care	October 2019
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 CLOSED ON THE BAF SEPT 19	Influence	Carole Robins Interim Chief Nurse and Quality Lead	October 2019
SO - 3 & 4 OG - 2, 3 & 4	BAF/060	Q&P RR / EMAS 01	**RISK** Ambulances unable to attend in a timely response **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 (monthly) • Quarterly QAG meetings and monthly EMAS CCM meetings • EMAS have completed and closed the 'must do' and 'should do' CQC action plans Attendance at monthly SI peer review meetings • Monthly Ambulance handover meetings with UHL/EMAS and commissioners	4	16	•Coordinating commissioner initiated Review under General Condition (GC) 8 on 18th December 2017 □ Internal definition for prolonged waits developed by EMAS and approved by their Quality Governance Committee in October 2017 □ First Bi-annual divisional C1 and C2 wait prolonged reviews are now completed. Reviews did not identify any harm as a result of EMAS prolonged waits. Plan to continue reviews and engage wider system to share the learning. □ LLR SI peer review of closed SIs in September 2018 identified key system learning actions which will be discussed at CCM and QAG. □ SI's continue to be reviewed monthly by regional peers to identify and share learning	Influence	Yasmin Sidyot Interim Director of Urgent & Emergency Care	October 2019

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 & 8 OG - 1 & 2	BAF/061	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. CLOSED ON THE BAF SEPT 19	Influence	Carole Ribbins Chief Nurse and Quality Lead	October 2019
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	2	8	•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. RISK CLOSED ON THE BAF - OCT 19	Influence	Yasmin Sidyot Interim Director of Urgent & Emergency Care	October 2019
SO - 3, 4 & 8 OG - 1, 2, 3 & 4	BAF/080	Q&P RR / EMAS 02	**RISK** Failure to meet ARP standards **IMPACT** patients don't receive a timely response **CAUSE** Increase in demand/ EMAS unable to recruit to planned workforce levels	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	Rating is consistent with commissioner colleague assessments in the context of contract expectation. EMAS did not meet standards by April 2019 and in recent contract negotiations EMAS have advised that they will by Quarter 2 of 2019/20 Performance is discussed at monthly Contract Meetings toward improvement.	Influence	Yasmin Sidyot Interim Director of Urgent & Emergency Care	October 2019
SO - 3, 4 & 8 OG - 1, 2, 3 & 4	BAF/077	Q&P RR / EMAS 03	**RISK** A high number of prolonged waits were identified in December 2017/18 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	Coordinating commissioner initiated Review under General Condition (GC) 8 on 18th December 2017 □ Internal definition for prolonged waits developed by EMAS and approved by their Quality Governance Committee in October 2017 □ First Bi-annual divisional C1 and C2 wait prolonged reviews are now completed. Reviews did not identify any harm as a result of EMAS prolonged waits. Plan to continue reviews and engage wider system to share the learning. □ LLR SI peer review of closed SIs in September 2018 identified key system learning actions which will be discussed at CCM and Page 4 of 50 QAG. □ SI's continue to be reviewed monthly by regional peers to identify and share learning	Influence	Yasmin Sidyot Interim Director of Urgent & Emergency Care	October 2019
SO - 3, 4 & 8 OG - 2 & 3	BAF/078	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 CLOSED ON THE BAF SEPT 19	Influence	Carole Ribbins Interim Chief Nurse and Quality Lead	October 2019

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 & 8 OG - 2	BAF/079	Q&P RR / TASL 04	**RISK** No quality reports have been received to date 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. .	4	16	• 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	Influence	Carole Ribbins Interim Chief Nurse and Quality Lead	October 2019
SO - 3, 5, 8 & 9 OG - 3	BAF/039	F&P (FP/RR/03)	**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) Financial Recovery plan in place	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 System Sustainability Group, SLT and CFOs Financial Recovery Plan monitored Sustainability Group	5	20	System Financial Recovery Plan reporting being extended to provide mnovement between schemes and months as well as detail on where pressures have materialised. (Nov 2019) NHSE Escalation of STP continues. Endeavour to find additional in-year savings opportunities to close risks within financial plans along side review for 20/21. (Oct 2019 - Jan 2020) potential assistance from NHS E/I to identify further in year savings.	Influence	Spencer Gay, Chief Financial Officer	October 2019
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 CLOSED ON THE BAF SEPT 19	Control	Spencer Gay, Chief Financial Officer	October 2019
SO - 3, 5, 8 & 9 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 Updated financial model for STP - Nov 2020 Financial Strategy agreed.	• Senior Leadership Team • CFO / DF meetings monthly •System Sustainability Group established	5	20	Refresh of 5 year model and development of long-term plan - Draft submitted, Final due for submission 15th Nov 2019 Process for refinement of savings plans to be agreed through System Sustainability group Nov 2019. Further schemes to deliver increased savings and support the five year plan are being discussed in various forums (with Clinical and system wide input)	Influence	Spencer Gay, Chief Financial Officer	October 2019
SO - 5, 8 & 9 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. System Financial Recovery Plan being constantly reviewed and updated. Development of new LLR 5 year plan, to be submitted 15/11/19	Control	Spencer Gay, Chief Financial Officer	October 2019

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 - 4 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 - Action complete - all practices have signed up SIRO sign up completed - which will enable greater functionality of Eclipse system - linked to SUS. Full implementation now expected Q2 2019/20. Now expected to start on Qtr 3 as currently working with Eclipse to customise the tool for polypharmacy across LLR 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. Action complete and being monitored in the monthly PMO workbook 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	October 2019
SO - 4 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 Ongoing streamlining of committees - discussion expected at October Board meeting Cross system review of skills gaps by SROs & teams	Influence	Spencer Gay Chief Financial Officer	October 2019
SO - 4 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 Any schemes/QIPP projects that are substantially off target will be escalated to the newly formed System Sustainability Group (SSG). This Group will look to challenge the off track schemes and identify any remedial actions to address obstacles to delivery	Influence	Spencer Gay (Simon Pizzey) Chief Financial Officer	October 2019
SO - 4 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 Any schemes/QIPP projects that are substantially off target will be escalated to the newly formed System Sustainability Group (SSG). This Group will look to challenge the off track schemes and identify any remedial actions to address obstacles to delivery	Influence	Spencer Gay (Simon Pizzey) Chief Financial Officer	October 2019
SO - 4 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 Any schemes/QIPP projects that are substantially off target will be escalated to the newly formed System Sustainability Group (SSG). This Group will look to challenge the off track schemes and identify any remedial actions to address obstacles to delivery	Influence	Spencer Gay (Simon Pizzey) Chief Financial Officer	October 2019
SO - 4 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 containing a QIPP planning shortfall of £4.9m System FInancial Recovery Plan development - July 19	Influence	Spencer Gay Chief Financial Officer	October 2019

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 - 3	BAF/067	CRR35	**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	3	12	• 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 • 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 • CCG Organisational Day outputs and actions being implemented • 'Getting our Mojo Back' is now called 'Keeping our Mojo' - work is ongoing with improved internal comms being delivered through a number of channels, celebrating successes and achievements, improving the working environment, people development etc. Additional areas to be considered in order to enable further progress and success - DR • AW briefing on 10 Oct outlining indicative timescales for management of change. A further briefing planned for 14 Nov • EMLA sessions being organised for staff to undertake	Influence	Ket Chudasama Director of Performance & Corporate Affairs	October 2019
SO - 3, 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 • SLT ToR approved - Jan 17 • Collaborative governance arrangement approved by LLR CCGs in Oct 19	Influence	Ket Chudasama Director of Performance & Corporate Affairs	October 2019
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	2	8	• Review of new model Constitution upon CCGs latest Constitution presented at CMT in Jan on and decision to pause on further changes until NHSE Commissioning Capability Programme outcomes are confirmed (SF) • Collaborative Governance Arrangements approved by LLR CCG GB in Oct - complete • CCG Constitution amendments to be sent to NHSE/I for approval (end of Nov) SF RISK CLOSED ON THE BAF - OCT 19	Influence	Caroline Trevithick Interim Accountable Officer	October 2019
SO - 3 & 4 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	Spencer Gay Chief Financial Officer	October 2019
SO - 5 & 9 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 and to be presented to GB • Chairs confirming arrangement within NHSE/I • AW briefing on 10 Oct outlining indicative timescales for management of change. A further briefing planned for 14 Nov	Influence	Ket Chudasama Director of Performance & Corporate Affairs	October 2019

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 OG - 2 & 3	BAF/008	Q&P RR / TASL 06	**NEW: Transferred from CRR (previoulsy CRR/65) - Sept 2019** **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.	5	• 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	20	• CCB update and position alongside contingency plans 21/02/2019. • Performance continues to be challenged, mainly linked with workforce turnover, attrition and recruitment. Call centre performance has improved in coordinating logistics and the TASL/UHL/LPT interface relationship remains positive in facilitating hospital discharges. Renal dialysis performance continues to improve. • TASL has undertaken consultation and begun a change in the management structure. The proposed new structure will see an increase in duty management capacity in the control centre and call centre throughout the day and into late evening. • 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. • CCG meeting with regional commissioners • Monthly updates to NHSE • Monthly Improvement task and finish group	Influence	Yasmin Sidyot Interim Director of Urgent & Emergency Care	October 2019
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 services, 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	3	12	• 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. CLOSED ON THE BAF OCT 19	Influence	Keri Chudasama Director of Performance & Corporate Affairs	October 2019
SO - 4 OG - 3	BAF/089	FPRR/69	**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	Spencer Gay Chief Financial Officer	October 2019
SO - 4 OG - 3	BAF/090	FPRR/70	**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 transformation is not achieved.	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	Spencer Gay Chief Financial Officer	October 2019
SO - 3 & 4 OG - 1 & 2	BAF/091	Q&P LPT/ RR/01	**NEW** **RISK:** Patient safety and quality / CQC report published as REQUIRES IMPROVEMENT IMPACT**:** poor patient outcomes and reputational damage CAUSE**:** severity of harm	4	NHSE oversight action TBC	monthly CQRG . Q&P PPAG	4	16	• continue monitoring actions • WLCCG is working with the ELCCG team.	Control	Carole Ribbins Interim Chief Nurse and Quality Lead	October 2019

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 - 4, 5 & 9 OG - 1, 2 & 4	BAF092	CRR66	**NEW** **RISK:** No Integrated Care Alliance within the LLR system **CAUSE:** Compelling future vision and scope not agreed or defined **IMPACT**: Failure to fully deliver service transformation	4	- Future Vision of Alliance paper presented to CCB in March - Alliance contract extended to March 2020 - Ket Chudasama and Dr Geoff Hanlon are members of ALB	- Alliance Leadership Board - CCB - GB - Alliance Management Board - SLT	3	**12**	- LPT chapter defines system and ICS roles and responsibilities - System wide workshop to be organised	Control	Ket Chudasama Director of Performance & Corporate Affairs	October 2019
Insert lines above here for new risks (this line shouldn't print)												

Appendix 2 - Risks removed from BAF - September 2019 onwards

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 - 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 CLOSED ON THE BAF SEPT 19	Influence	Carole Ribbins Interim Chief Nurse and Quality Lead	October 2019
SO - 3 & 8 OG - 1 & 2	BAF/061	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. CLOSED ON THE BAF SEPT 19	Influence	Carole Ribbins Chief Nurse and Quality Lead	October 2019
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	2	8	•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. RISK CLOSED ON THE BAF - OCT 19	Influence	Yasmin Sidyot Interim Director of Urgent & Emergency Care	October 2019
SO - 3, 4 & 8 OG - 2 & 3	BAF/078	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 CLOSED ON THE BAF SEPT 19	Influence	Carole Ribbins Interim Chief Nurse and Quality Lead	October 2019

OG - 3	BAF/081	F&P (FP/RR28)	**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 CLOSED ON THE BAF SEPT 19	Control	Spencer Gay, Chief Financial Officer	October 2019
SO - 5 OG - 3 & 4	BAF/068	CRR152	**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	2	8	• Review of new model Constitution upon CCGs latest Constitution presented at CMT in Jan on and decision to pause on further changes until NHSE Commissioning Capability Programme outcomes are confirmed (SF) • Collaborative Governance Arrangements approved by LLR CCG GB in Oct - complete • CCG Constitution amendments to be sent to NHSE/I for approval (end of Nov) SF RISK CLOSED ON THE BAF - OCT 19	Influence	Caroline Trevithick, Interim Accountable Officer	October 2019
OG - 1 & 2	BAF/071	LLR IG RR15	**Risk** There is a risk to the confidentiality of pcd, to the availability of all systems and services, and to the provision of health services, 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	3	12	• 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. CLOSED ON THE BAF OCT 19	Influence	Kel Chudasama Director of Performance & Corporate Affairs	October 2019
Insert lines above here for new risks (this line shouldn't print)													