PAPER I

WEST LEICESTERSHIRE CLINICAL COMMISSIONING GROUP

BOARD MEETING

10 November 2015

Title of the report:	Board Assurance Framework
Section:	Governance – How we manage our business
Report by:	Laura Rodman – Corporate Affairs Officer Geoff Stokes – Interim Head of Corporate Governance
Presented by:	Ket Chudasama – Assistant Director Corporate Affairs

Report supports the following West Leicestershire CCG's goal(s) 2012 – 2015:			
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 30 October 2015
Discussed by	CCG sub-groups in October 2015 CMT, 26 October 2015
Alignment with other strategies	2014-15 and 2015-16 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 Board Assurance Framework (BAF) has been reviewed and updated to show the latest position as at 30 October 2015. The BAF contains risks to the achievement of strategic objectives for the year, plus other risks 'escalated' from the constituent risk registers where there is an inherent risk rating of 12 or more. As at 31 October 2015 the red rated risks are:

    - Failure to assure local health economy financial viability over the next five years
    - The quality of care provided by UHL does not match commissioner's expectations with respect to quality and safety
    - Patient safety risk due to capacity of EMAS
    - Clinical risk associated with poor performance of CNCS OOH service
    - Safe staffing concerns across Community Health Services and at the Mental Health Services Divisions
    - Failure to improve A&E performance
    - Failure to improve 18 week RTT performance

2. A review of the BAF is also underway and the paper describes specific recommendations arising from that review about changing the way that risks are described and the frequency at which the BAF is reviewed.
3. At the previous meeting it was agreed to review one or two risks in depth. The paper proposes an in depth discussion about one of the risks, where the principles have been applied as this will allow the risk itself to be reviewed along with a test of the principles

RECOMMENDATIONS:

The West Leicestershire Clinical Commissioning Group is requested to:

APPROVE the latest iteration of the 2015/16 Board Assurance Framework

DISCUSS if any further actions are required to address the risks

APPROVE the following recommendations arising from the ongoing review

a. That the Board review of the BAF move to quarterly, starting from January 2016
b. That risks are reworded to reflect the CCG's Risk Management Strategy and Policy

DISCUSS risks 1.1 and 2.1 in depth, to gain assurance about how they are being managed

WEST LEICESTERSHIRE CLINICAL COMMISSIONING GROUP
BOARD MEETING

10 November 2015

BOARD ASSURANCE FRAMEWORK

INTRODUCTION

1. The Board Assurance Framework (BAF) has been reviewed and updated and shows the latest position as at 31 October 2015. The updated BAF contains risks to the achievement of strategic objectives for the year, plus other risks 'escalated' from the constituent risk registers where there is an inherent risk rating of 12 or more. It is attached as appendix 1.

2. The following matrix shows the position as at 31 October 2015:

IMPACT / CONSEQUENCE	1 Rare	2 Unlikely	3 Possible	4 Likely	5 Almost Certain
5 Catastrophic	5	10	15 Failure to improve A&E performance ↓ Failure to improve 18 week RTT performance ⇔	20	25
4 Major	4	8	12 LLR Learning Lessons to Improve Care ⇔ Failure to maintain control of CCG financial position ⇔	16 The quality of care provided by UHL does not match commissioner's expectation ⇔ Patient safety risk due to capacity of EMAS ⇔ Clinical risk associated with poor performance of the CNCS OOH service. ⇔ Safe Staffing (nursing) concerns across Community Health Services and at the Mental Health Services Divisions ⇔	20 Failure to assure local health economy financial viability over the next 5 years. ⇔
3 Moderate	3	6	9	12 Concerns relating to the Mental Health Acute Pathway ⇔ A lack of capacity in the GEM CHC team ⇔ Poor financial control and opportunity for fraud on Continuing Healthcare. ⇔ Initial health assessments for looked after children ⇔ Limited community therapeutic support for children with eating disorders NEW	15
2 Minor	2	4	6	8	10
1 Negligible	1	2	3	4	5
	LIKELIHOOD				

3. Board members are asked to note that there are five key urgent care risks which are reported to the Urgent Care Board. These risks and their mitigating actions are included in the consolidated A&E risk (1.6) and EMAS capacity risk (1.3) on our CCG BAF, however, members are asked to note these specific urgent care risks which are a sub-set of our BAF urgent care risks. The risk position below is as at October 2015.

Risk Description	Key Controls	Net Risk Score
Patients could receive sub-optimal care, including increasing risk of harm as a direct result of increasing pressures in urgent care pathway due to:		
1 Lack of EMAS capacity resulting from volume/handover issues leading to patients waiting 'unsighted' in the community for a first response following initial telephone triage.	• Additional resources on overtime or VAS/PAS to provide cover at projected peaks. • Emergency Conveyance reduction - Pathfinder Training ongoing Q3 2015/16. • Emergency Conveyance reduction - Falls Training option will be an in-house EMAS delivery – Timeframe TBC in Q4 • EMAS wide REAP level 4 actions.	**4 x 4 = 16** ↑
2 Overcrowding in ED/CDU leading to risk of high need patients being incorrectly prioritised and/or not being assessed and treated in line with their relative priority.	• Weekly audit of ED metrics. • Staffing flexed to ensure nursing and medical staffing ratios appropriate for managing patients cohort. • Triage at ED front door. • Process for reviewing long wait patients by "safety doctor". • "Safety doctor" available to support ED. • Real-time monitoring of ED activity. • Implementation of ED action plan in response to I Sturgess report (endorsed by NTDA). • Gold Command Meetings (led by UHL Director 7 days a week). • Increased Consultant presence at weekends on our key medical wards at the LRI.	**4 x 4 =16** ↔
3 Handover delays for EMAS crews at LRI leading to risk of patients condition deteriorating while waiting.	• Dynamic HALO deployed to assist with pre-handover delays. • Regional Operations Manager role introduced in EOC. • LLR/UHL Task & Finish Group	**4 x 4 = 16** ↑

Risk Description	Key Controls	Net Risk Score
	established to review progress and implement improvements. • System performance conference calls at weekends - EMAS, UHL, UCC and CCGs.	
4 Short notice cancellation of elective procedures as a result of bed availability resulting in patients (including cancer patients) deteriorating while waiting for treatment to be rescheduled	• Daily Bed Meetings to identify capacity risks and make plans to mitigate risks. • Resilience planning when electives admissions are high and cases discussed in the gold meeting, where necessary. • As per the UHL Cancelled Escalation Policy, staff will highlight any risk of cancellations to project manager in the first place and plans are made to mitigate the risk. This process has been successful to reduce cancellations. • LIA project. • Scheduling changes to area impact due to emergencies. • For ITU capacity: – Improving the use of Critical Care – Expanded the ITU capacity by 4 beds on all three sites in 2015 – Using ICU staff flexibly across all three sites – Introduction of a bank staff system – Working with surgical specialities to manage demand – Potential discharges identified day before and plans are identified.	**4 x 3 =12** ↓
5 Ability to delivery maximum staffing levels 24/7 may cause delays in treatment compliance and care delivery having the potential to cause harm	**UHL** • UHL and LPT - hard truths staffing data monitored routinely. • Use of bank staff and locum staff where available including agency staff off NHS payment framework. • Staffing flexed across sites to manage greater risk areas. • UHL - ward metrics in place to monitor and oversee ward performance. • Twice Yearly Acuity monitoring.	**4 x 4 =16** ↔

Risk Description	Key Controls	Net Risk Score
	• 7 day onsite senior management presence	
5 Overstretched nursing and medical ward staff cover in UHL acute and LPT community hospital beds leading to harm from delays in care, treatment compliance and patient deconditioning	**LPT** • Shift by shift review of staffing on community hospital wards and movement as required. Use of bank staff and locum staff where available. • Enhanced medical inpatient model utilising ANP's and geriatricians for community hospitals is in place. • Full week acuity review underway for one month in community hospitals and MHSOP, week commencing 5th January to establish more accurate staffing levels. • Increased monitoring through locality governance, risk register review and incidents, complaints and SI review. • MHSOP Staff levels increased above budgeted establishment through agency and bank deployment in line with patient dependency and severity until new recruits are in post and inducted. **AMH** • Shift by shift management of staffing requirements and use of bank and agency to maintain safe staffing levels. • Staffing contingency plans in operation and ongoing recruitment. • Increased monitoring through weekly operational meetings, safer staffing activity, divisional risk register review, incidents and SIs • Monitoring of e-rostering to ensure efficient usage of staff • Staffing workshop held on 29/04/15 **FYPC** • Staffing levels for in-patients monitored on individual shift basis. On-call staffing is monitored daily and discussed with operational managers and reported on at weekly ops. Any breaches that occur to due to lack of capacity are reported, escalated and investigated.	**3 x 3 =9**

4. As at 31 October 2015 September 2015 the highest scoring risks along with their mitigating actions and next steps are as follows:

Risk Description	Risk Score	Risk scores		Actions in the next period
	Impact	Likelihood	Rating	
Failure to assure local health economy financial viability over the next 5 years.	**4**	**5**	**20 (R)** ⟷	Implentation of year 1 project actions Updating organisational financial models - WLCCG medium term draft plan due for submission 11th September 2015 Source of transitional funding to be secured to enable change to take place in future years Implementation/Contractual Agreement of Bed Reconfiguration phase 1 Drafting Pre-consultation Business Case prior to November Consultation, including impact of consultation options and refresh of 5 year financial outlook
The quality of care provided by UHL does not match commissioner's expectation with respect to quality and safety, due to a deterioration in performance across a number of areas: - poor performance across the urgent care pathway - deterioration in RTT performance - 62 day cancer waits at speciality level - disparity of SHMI across sites (high SHMI at LRI site) - inconsistency in FFT across wards	**4**	**4**	**16 (R)** ⟷	Despite LLR CCGs oversight and scrutiny performance at across the range of services continues to give significant cause for concern and has not yet reduced the risk (reviewed monthly). Performance against national 4 hr ED is not achieving acceptable levels despite focussed efforts within UHL (reviewed monthly). Monitoring via CQRG, RTT Board, CPM and technical meetings, Cancer Board, Cancer action group. This is reviewed at PPAG. UHL to ensure plans in place to meet the targets set on trajectories. Problem areas that need extra scrutiny are upper and lower GI and lung. Currently backlog is 125 at the end of April. Trajectory states it should be 60, UHL to provide action plan to bring back target.
Patient safety risk due to capacity of EMAS to deliver Red 1 and A19 requirements and the issuing of an improvement notice from CQC (2013), which highlights certain patient risks. CQC revisit (2014) continues highlight concerns	**4**	**4**	**16 (R)** ⟷	• Better Patient Care report has been provided to Commissioners providing assurance on progress against the EMAS Quality Improvement Plan • Poor progress on the CQC Action Plan escalated to the Partnership Board, • Collaborative Commissioning Meeting and EMAS Quality Governance Committee. • Patient Safety issues in light of the change of practice for transfer of Critical Care • Patients have been addressed by escalation of the concerns and an immediate reinstatement of these transfers • EMAS has acknowledge misinterpretation of the contract in relation to the Critical • Care Transfers and have reinstated this service with immediate effect • Local issues are being addressed through the Locality meeting • Close liaison with UHL to address Handover and Turnaround • Handover and Turnaround working group set up and initial actions agreed, to be reviewed in terms of impact after one month •Falls Pathway under review •Address any concerns identified through monitoring of SI's, incidents and complaints •Monitoring issues escalated by primary medical care •Escalate concerns to monthly NTDA Oversight Group. Review of the new CQC process and the impact on providers.
Clinical risk associated with poor performance of the CNCS OOH service.	**4**	**4**	**16 [R]** ⟷	Contract and Quality leads to asses performance against trajectory Monitoring of complaints and incidents Weekly monitoring of staffing and rotas Unannounced visits to service to assess risks

Risk Description	Risk Score	Risk scores		Actions in the next period
	Impact	Likelihood	Rating	
Safe Staffing (nursing) concerns across Community Health Services and at the Mental Health Services Divisions (Bradgate Mental Health Unit) may impact on the quality and continuity of care for patients. This is due to gaps in the substantive nursing workforce and significant reliance on temporary staff to fill gaps in availability.	4	4	16 [R] ⟷	Lead nurse for Quality to meet with LPT to review the information provided to CQRG and to seek assurance regarding risks mitigation.
Failure to improve A&E performance leading to removal of the CCG's responsibility to commission urgent care services	5	3	15 [R] ↓	Ongoing Monthly contractual performance review. Weekly Urgent Care Meetings take place under the LLR Resilience Governance Plan. External clinical consultant in post working with UHL to identify pathway changes over a period of 6 months. Daily remedial actions undertaken daily by Emergency Care Director. New urgent care plan and recovery tragectory built in to 2015/16 plans. A&E performance at the end of February had deteriorated and is at 86.63% compared to January, however this has recovered again in march with a current monthyl average of 87.6% showing . Activity has not changed significantly although the number of admissions has increased and is currently 12% above last years position. The A&E metrics are agreed but are only being met in part. Performance is monitored through PPAg on a monthly basis. Daily remedeial actions undertaken by Emergency Care Director.
Failure to improve 18 week RTT performance leading to removal of the CCG's responsibility to commission elective services	5	3	15 (R) ⟷	~~Ongoing monthly contractual performance review.~~ Embedding of robust monitoring arrangements via RTT Board. Ensure RTT Board provides appropriate focus on sustainability. As a result of concerns re diagnostics there will now be a focussed piece of work on direct access to MRI. RTT Board agreed to monitor the following on a weekly basis. Clock stops actual against plan Backlog actual against plan Performance actual against plan On a monthly basis to monitor clearance times on a quarterly basis to monitor referrals demand and impact of emergency admissions. Rollout of MSK Triage in West Leicestershire CCG in July 2015. Review and monitoring of Out of County performance and issues through Planned Care Delivery Group (reports by exception into Planning and Delivery Sub Group).

5. Individual risk registers are maintained by the three sub-groups and by CMT, and are reviewed on a monthly basis. In addition, the Audit Committee provides further scrutiny and challenge on the risk registers and BAF at each meeting. The detailed registers are available to Members for review at any time.

REVIEW OF BOARD ASSURANCE FRAMEWORK

6. The BAF is currently under review and a number of suggestions are emerging about how to improve its effectiveness in assuring the Board that key risks are being managed in line with the CCG's Risk Management Strategy and Policy.

7. Rewording risks to explicitly reflect the CCG's approach to articulating the risk (step 2 in table 1 of the strategy), should make risks clearer, especially their cause and impact. An illustration of this is shown at appendix 2 and it is proposed that all risks are reworded in this way. (NB these two risks are those

suggested by CMT for Board to review in depth). It should then be easier to assess the relevance and effectiveness of the controls and actions relating to each risk.

8. There will need to be some discussion about the wording of risks that are shared between the 3 CCGs to ensure consistency.

9. Reviewing the BAF at every Board meeting gives rise to the potential that not enough movement happens between reviews so the document is not scrutinised thoroughly. A less frequent, but more thorough, review should help to improve the quality of the BAF.

10. Reviewing the BAF quarterly will also create some capacity for discussions between risk owners and members of the Corporate Affairs team to ensure that only relevant controls and actions are included, and that updates are meaningful. These discussions will take place during the quarter (rather than at the end) so that no risk should have gone more than 3 months without being reviewed.

11. Further developments to the way that risks are presented and summarised, including the 5x5 matrix and the concentric diagram, are also being worked on.

12. The Risk Management Strategy and Policy is due for renewal in February 2016 and these and other changes (if agreed) will be incorporated into the redraft.

RECOMMENDATIONS:

The West Leicestershire Clinical Commissioning Group is requested to:

APPROVE the latest iteration of the 2015/16 Board Assurance Framework

DISCUSS if any further actions are required to address the risks, specifically risks 1.1 and 2.1

Appendix 1 Board Assurance Framework as at 31 October 2015
Appendix 2 Extract from BAF showing 2 re-worded risks for discussion

Board Assurance Framework 2015/16 - October 2015

Risk Reference	Strategic Objective	Risk Owner	Risk Description	Risk Score: Impact	Ongoing Actions	Monitoring	Risk scores: Likelihood	Risk scores: Rating	Actions in the next period	Last reviewed
1.1	3a, 3b, 3c & 3d	Spencer Gay (CFO)	**Failure to assure local health economy financial viability over the next 5 years.**	4	BCT programme established Permanent programme director appointed SOC agreed and submitted to TDA / NHS England	BCT board meetings CFO / DF meetings monthly	5	20 (R) ⟷	Implentation of year 1 project actions Updating organisational financial models - WLCCG medium term draft plan due for submission 11th September 2015 Source of transitional funding to be secured to enable change to take place in future years Implementation/Contractual Agreement of Bed Reconfiguration phase 1 Drafting Pre-consultation Business Case prior to November Consultation, including impact of consultation options and refresh of 5 year financial outlook	Oct-15
1.2	1a, 2a & 2b	Caroline Trevithick (CNQL)	**The quality of care provided by UHL does not match commissioner's expectation with respect to quality and safety, due to a deterioration in performance across a number of areas:** - poor performance across the urgent care pathway - deterioration in RTT performance - 62 day cancer waits at speciality level - disparity of SHMI across sites (high SHMI at LRI site) - inconsistency in FFT across wards	4	Collaborative commissioning arrangements in place (Commissioning Collaborative Board and Provider Performance Assurance Group). Memorandum of agreement between LLR CCGs in place governing collaborative arrangements. Monthly contract meetings. Review and robust challenges to data by LC CCG Hosted Team. Actions pursued via contractual arrangements.	Monthly Integrated quality & performance reports reviewed by Performance Collaborative and individual organisation subcommittees/ Governing Body Triangulation of data to inform unannounced quality visits Oversight and scrutiny and sign off of Serious Incidents GP concerns reporting mechanism	4	16 (R) ⟷	Despite LLR CCGs oversight and scrutiny performance at across the range of services continues to give significant cause for concern and has not yet reduced the risk (reviewed monthly). Performance against national 4 hr ED is not achieving acceptable levels despite focussed efforts within UHL (reviewed monthly). Monitoring via CQRG, RTT Board, CPM and technical meetings, Cancer Board, Cancer action group. This is reviewed at PPAG. UHL to ensure plans in place to meet the targets set on trajectories. Problem areas that need extra scrutiny are upper and lower GI and lung. Currently backlog is 125 at the end of April. Trajectory states it should be 60, UHL to provide action plan to bring back target.	Oct-15
1.3	1a, 1b, 2a, 2c, 3b & 3c	Caroline Trevithick (CNQL)	**Patient safety risk due to capacity of EMAS** to deliver Red 1 and A19 requirements and the issuing of an improvement notice from CQC (2013), which highlights certain patient risks. CQC revisit (2014) continues highlight concerns	4	Financial sanctions Local quality monitoring with EMAS Local performance meetings with EMAS Discussion with GEM regarding reporting timelines has taken place Recovery Action Plan in place which has had oversight by the Trust Development Agency (TDA), the Care Quality Commission (CQC) and regional commissioners - monthly meetings to review progress commenced in January 2014. GEM Comms team to pick up any local media issues.	Locality Meetings Quality Assurance Group Meetings (QAG) Recovery Action plan in place - Better Patient Care Programme Dashboard (QIP) Monitoring serious incident reports, incident data and complaints Monthly meetings to act on hot topics Risk summit (QIP) EMASs CQC Action Plan Task and Finish Group Report to Q&P sub-group. TDA oversight group in place	4	16 (R) ⟷	• Better Patient Care report has been provided to Commissioners providing assurance on progress against the EMAS Quality Improvement Plan • Poor progress on the CQC Action Plan escalated to the Partnership Board, • Collaborative Commissioning Meeting and EMAS Quality Governance Committee. • Patient Safety issues in light of the change of practice for transfer of Critical Care • Patients have been addressed by escalation of the concerns and an immediate reinstatement of these transfers • EMAS has acknowledge misinterpretation of the contract in relation to the Critical • Care Transfers and have reinstated this service with immediate effect • Local issues are being addressed through the Locality meeting • Close liaison with UHL to address Handover and Turnaround • Handover and Turnaround working group set up and initial actions agreed, to be reviewed in terms of impact after one month •Falls Pathway under review •Address any concerns identified through monitoring of SI's, incidents and complaints •Monitoring issues escalated by primary medical care •Escalate concerns to monthly NTDA Oversight Group. Review of the new CQC process and the impact on providers.	Oct-15
1.4	1a, 1b, 2a, 2c, 3b & 3c	Caroline Trevithick (CNQL)	**Clinical risk associated with poor performance of the CNCS OOH service.**	4	Monthly CQRG Monthly Contract meetings Remedial action plan with trajectory in place Ad hoc clinical quality meetings with provider	CQRG Contract Performance meeting Oversight meetings	4	16 (R) ⟷	Contract and Quality leads to asses performance against trajectory Monitoring of complaints and incidents Weekly monitoring of staffing and rotas Unannounced visits to service to assess risks	Oct-15
1.5	1a, 2a & 2b	Jim Bosworth	**Safe Staffing (nursing) concerns across Community Health Services and at the Mental Health Services Divisions** (Bradgate Mental Health Unit) may impact on the quality and continuity of care for patients. This is due to gaps in the substantive nursing workforce and significant reliance on temporary staff to fill gaps in availability.	4	The Trust is required via the Contract Quality Schedule to demonstrate; a) Safe staffing levels (in line with staffing levels NHSE), b) A safe and effective workforce provision c) Sustainable improvements in MH Services d) Quality metrics for Bradgate Mental Health Unit (monthly) Additionally the following has been requested of the Trust: - Undertake a deep dive into the staffing levels at the Bradgate Unit, identifying gaps and how they are being addressed. - Provide commissioners with further detail on the 'rolling recruitment process' that the Trust has said is currently in place for the Bradgate Unit. - Undertake a risk assessment of all of the wrads relating to safe staffing levels following the closure of St Luke's ward. - Provide detail to enable commissioners to gain an understanding of the Trust recruitment strategy.	Monthly detailed reporting to CQRG of staffing levels at ward level and recruitment/vacancy levels by division. To include actions relating to addressing staffing shortages and mitigating risks to patients. Regular 1 to 1 meetings between the Director of Nursing and Quality (LCCCG) and Cheif NUrse (LPT). The Trusts formal response to the specific information requests to the CQRG. Safer staffing reports to LPT Trust Board (monthly and 6 monthly). • Undertake a deep dive into the staffing levels at the Bradgate Unit, identifying gaps and how they are being addressed. • Provide commissioners with further detail on the 'rolling recruitment process' that the Trust has said is currently in place for the Bradgate Unit. • Undertake a risk assessment of all of the wards relating to safe staffing levels following the closure of St Luke's ward.Provide detail to enable commissioners to gain an understanding of the Trust recruitment strategy.	4	⟷ 16 [R]	Lead nurse for Quality to meet with LPT to review the information provided to CQRG and to seek assurance regarding risks mitigation.	Oct-15

Risk Reference	Strategic Objective	Risk Owner	Risk Description	Risk Score: Impact	Ongoing Actions	Monitoring	Risk scores: Likelihood	Risk scores: Rating	Actions in the next period	Last reviewed
1.6	**1a, 1b, 2a, 2b, 2d, 3b & 3d**	**Caron Williams (ADSP)**	**Failure to improve A&E performance** leading to removal of the CCG's responsibility to commission urgent care services	**5**	Performance has stabalised at current performance level. The Urgent Care Board have developed a new plan to take the perfomance to 95%. The meetings have been moved to fortnightly, to allow the elements to work through the UCWG sub-groups. 4 action areas have been identified each with a series of actions which can generate rapid solutions or interventions. Weekly progress against the short-term RAP is monitored by the Hub at the weekly delivery group and then reported into the Urgent Care Board. This is being underpinned by KPI's (key performance indicators) for each of the work streams to support the monitoring of performance and delivery against intended outcomes. UHL Contract Management Team hosted by City CCG. Monthly contract technical, performance and CQRG meetings will escalate issues via Provider Performance Assurance Group to CCG Boards for action. UHL dashboards produced weekly and closely monitored at the UCB	CCG formal Collaborative Commissioning arrangements agreed. Monthly Technical and CPM minutes for major contracts. Governing Body contract performance reports, minutes and papers. Urgent care working group reports and minutes Terms of Reference for Provider Performance Assurance Group, agreed by GB, including reports/papers and minutes of meetings. Weekly Urgent Care Board meeting agendas, reports and minutes. National standards checklist in place informing the recovery plan. High impact interventions in place that are monitored weekly. Interim report from Ian Sturgess available to CCGs with key focus on clinical leadership.	**3**	**15 [R]** ↓	Ongoing Monthly contractual performance review. Weekly Urgent Care Meetings take place under the LLR Resilience Governance Plan. External clinical consultant in post working with UHL to identify pathway changes over a period of 6 months. Daily remedial actions undertaken daily by Emergency Care Director. New urgent care plan and recovery tragectory built in to 2015/16 plans. A&E performance at the end of February had deteriorated and is at 86.63% compared to January, however this has recovered again in march with a current monthyl average of 87.6% showing . Activity has not changed significantly although the number of admissions has increased and is currently 12% above last years position. The A&E metrics are agreed but are only being met in part. Performance is monitored through PPAg on a monthly basis. Daily remedeial actions undertaken by Emergency Care Director.	Oct-15
1.7	**1a, 1b, 2a, 2b, 2c, 2d, 3a, 3b, 3c & 3d**	**Caroline Trevithick (CNQL)**	**Failure to improve 18 week RTT performance** leading to removal of the CCG's responsibility to commission elective services	**5**	UHL Contract Management Team hosted by City CCG. Monthly contract technical, and CPM meetings escalate issues via Provider Performance Assurance Group to CCG Boards for action. UHL dashboards produced monthly and closely monitored. Non recurrent and recurrent additional funding identified through transformational funding and contract envelope for 2015/16. RTT Board established 23.04.14 to hold UHL to account. Individual CCGs developing RTT plans to ensure delivery against NHS Constitution requirements. National RTT recovery exercise (part of resilience planning) has required revised plans for additional activity, outsourcing, promotion of patient choice and data validation. Progress monitored fortnightly through RTT Board with weekly/twice-weekly telecons to monitor operational implementation. National exercise for the transfer for elective patients to the IS sector with national additional funding. Now confirmed as benefiting long waiting	Minutes of Technical and CPM minutes including progress reports and exception reports. Governing Body contract performance reports, minutes and papers. Terms of Reference for Provider Performance Assurance Group, agreed by GB, including reports/papers and minutes of meetings. Contract management correspondence with UHL:1. RTT RAPS RTT Board minutes, agendas and papers. MDs minutes, agendas and papers. Assurance that non admitted and incompletes performance already meeting.	**3**	**15 (R)** ↔	Ongoing monthly contractual performance review. Embedding of robust monitoring arrangements via RTT Board. Ensure RTT Board provides appropriate focus on sustainability. As a result of concerns re diagnostics there will now be a focussed piece of work on direct access to MRI. RTT Board agreed to monitor the following on a weekly basis. Clock stops actual against plan Backlog actual against plan Performance actual against plan On a monthly basis to monitor clearance times on a quarterly basis to monitor referrals demand and impact of emergency admissions. Rollout of MSK Triage in West Leicestershire CCG in July 2015. Review and monitoring of Out of County performance and issues through Planned Care Delivery Group (reports by exception into Planning and Delivery Sub Group).	Oct-15
1.8	**1a, 1b, 2a & 2b**	**Caroline Trevithick (CNQL)**	**LLR Learning Lessons** to Improve Care published July 2014, potential risk of loss of confidence in local NHS providers regarding ability to implement actions required	**4**	5 point action plan updated Clinical Task Force in place with engagement with all agencies Clinical and Public Engagement Events - Information generated now being analysed Audit will be repeated to enable robust monitoring and to ensure that the 5 point action plan is delivering required results	Programme timeline agreed and included in March board report LLR Learning Lessons to Improve Care Clinical Taskforce in place to monitor operational management of Action Plan 5 point action plan to be incorporated into the Better Care Together plan. Link to Better Care Together Programme formalised Clinical and managerial oversight of actions Quarterly reporting to CCG. Next one March 2015 Respond to concerns raised by LMC and Healthwatch regarding actions and progress	**3**	**12 (A)** ↔	Monitor and respond to media/public/stakeholder interest Establish governance arrangements for ongoing monitoring of action plan i.e. present update on action plans to CCG Board in 3 months - update to be received in March 15 Respond to concerns raised by LMC and Healthwatch regarding actions and progress Interim Project Manager in place to finalise and collate progress to date and granular action plan that supports implementation of the overarching joint action plan Update to be presented at CCG Board in March.	Oct-15
1.9	**1a, 1b, 2a, 2b & 3a**	**Jim Bosworth**	**Due to concerns relating to the Mental Health Acute Pathway,** in particular quality and patient safety as identified by the CQC inspection, capacity, timely crisis response and poor quality performance data there is a potential risk that the access and service quality provision for patients could be affected	**3**	Plan agree with LPT to address the CQC findings. Crisis House opened February 2015. Contractual agreement for LPT to manage risk has improved patient flow and reduced overspill. Clinical Forum has agreed a new crisis pathway which is being implemented.	Joint arrangements with the TDA to monitor implementation of CQC plan. Monthly reports to Contracting Structure & Mental Health Clinical Forum. Informal patient feedback.	**4**	**12 (A)** ↔	Continued monitoring of pathway through contractual meetings and Clinical Forum.	Oct-15

Risk Reference	Strategic Objective	Risk Owner	Risk Description	Risk Score: Impact	Ongoing Actions	Monitoring	Risk scores: Likelihood	Risk scores: Rating	Actions in the next period	Last reviewed
2.0	2a, & 2b	Caroline Trevithick (CNQL)	**A lack of capacity in the GEM CHC team** has created a risk to the welfare of CHC funded patients, due to a large number of case reviews being overdue	3	Process in place for CHC to undertake reviews in order of priority i.e. those which have no mainstream health involvement, safeguarding issue, longest time since last review etc. Strategic Plan developed regarding capacity issues - Report / Paper to CHC Board in April 2013 and Joint Managing Director meetings requesting 5 additional members of staff - CHC Board attended represented by each CCG - MI, Chief Finance Officer. Internal Audit undertook a CHC review, report issued in January 2013 with 'Limited Assurance' and 20 audit recommendations - tabled at LC CCG's Audit Committee in January 2013 - Progress monitored by CHC Management Board and Corporate Affairs Team. Monthly meetings with senior managers CCG/GEM Additional support identified from wider GEM team.	CHC Management Board to monitor backlog monthly (established in March 2013) Internal monitoring process for CHC. CHC Board reports / papers and minutes of meetings, including details of attendance. CHC CPM meetings monitoring trajectory monthly.	4	12 (A) ⟷	GEM CHC have undertaken a recruitment process to ensure that all posts are filled. This is an ongoing process to fill new vacancies. The CHC team are now sharing this information with the contract team on a regular basis. The GEM CHC contract performance team receives monthly information regarding overdue reviews to ensure that a backlog doesn't build up. GEM CHC to develop a mitigation plan with controls and assurance. This is now monitored on a monthly basis on East CCG PPAG register. Service improvement plan in place.	Oct-15
2.1	3a, 3b, 3c and 3d	Spencer Gay (CFO)	**Failure to maintain control of CCG financial position and deliver statutory duty to breakeven over the coming 5 year planning period.**	4	5 year plan developed March 2014. First draft uodated 15/16, 16/17 plan submitted to NHS E Nov 14. Balanced financial plan in place for 2015/16. Refreshed 3 Year Plan produced in 15/16 Q2.	Finance committee for review of plan and monitoring of performance Board for review of plan and monitoring of performance	3	12 (A) ⟷	Investigate oppurtunities to reduce risk through fixed contract values Review QIPP schemes for feasibility & monitor achievement Ensure consistancy of QIPP with BCF and BCT programmes Produce a refreshed 5 Year plan during Q2 of 2015/16 Focus to ensure sufficient QIPP in pipeline from 16/17 and beyond.	Oct-15
2.2	2c, 2d, 3a, 3b, 3c and 3d	Spencer Gay (CFO)	**Poor financial control and opportunity for fraud on Continuing Healthcare.**	3	High cost placements are scrutinised by a panel CCG signatories have been identfied Internal Audit - recommendations to be implemented	Annual review of each patient Monthly CCG level reporting of spend Scrutiny of invoicing of deceased patients	4	12 (A) ⟷	Ensure all annual reviews are up to date and appropriately conducted - This is now on track Consider annual audit - requested it is covered by GEM Service Auditor report in 15/16 - Not undertaken in 14/15. Monitoring of GEM performance through KPIs and Milestones over the forthcoming three months. Expansion of CHC team agreed with specific milestones and incentives to review packages and clear backlogs	Oct-15
2.3	2a, 2b, 2c	Caroline Trevithick (CNQL)	**Initial health assessments for looked after children are not being completed within the statutory time frame.**	3	Initial health assessments for looked after children are not being completed within the statutory time frame. (Statutory Guidance on Promoting the Health and Well-being of Looked After Children 2009) of 28 days. Therefore a health care plan is not available for the child/young person's first review of their foster care placement 28 days after entering care. To resolve this issue the following is required: • Timely notification from local authority social care departments to health • Adequate number of IHA Clinics provided by LPT Ensuring improved timescale for completion of IHA is a key priority for the Leicestershire and Rutland Local Safeguarding Children Board and has been highlighted by a recommendation from a current Child Serious Case Review. The issue has been highlighted by a Leicester City LSCB Ofsted Inspection. The importance of timely IHAs has also been acknowledged by the East Leicestershire and Rutland CCG and West Leicestershire CCG Performance and Quality Meetings.	In February 2015 the CCG raised a Contract Query in relation to the underperformance of LPT to meet the required standards. The LPT has responded by increasing IHA Clinic availability from 1st March 2015 to include up to 70 IHA Clinic appointments a month. This increase in clinic availability will manage the backlog of IHA and enable timely assessments for all new appointments.	4	12 (A) ⟷	CT and JH will provide data that reflects the child's journey. This will support the Executive Nurses discussion with the Directors of Social Care about the issue of late notification of IHAs by the local authorities. Awaiting results of LPT Q4 performance monitoring by the CCG Contracts team.	Oct-15
2.4	1b, 2b, 2d, 3a, 3c, 3d	Melanie Thwaites (AD, Children and Families)	**Limited community therapeutic support for children with eating disorders [NEW]**	3	A working group has been established to build a business case for increased service provision. NHS England have indicated that funding is available	FYPC Sub committee of the Contract Performance Meeting	4	12 [A] NEW	LPT have verablly agreed an increase in risk. Commissioners have written to ask for confirmation and clarity of the issues Leon Charikar to work with NHS England to establish funding options Proposal to commissiona specialist community service for children with eating disorders is being conisdered by CCGs The risk is also on the PPAG risk register and is reviewed on a monthly basis	Oct-15

Board Assurance Framework 2014/15 - October 2015 (EXTRACT - SAMPLE UPDATED)

Risk Reference	Strategic Objective	Risk Owner	Risk Description	Risk Score: Impact	Ongoing Actions	Monitoring	Risk scores: Likelihood	Risk scores: Rating	Actions in the next period	Last reviewed
1.1	3a, 3b, 3c & 3d	Spencer Gay (CFO)	**RISK** That the local health economy is not financially viable over the next 5 years **CAUSE** Increasing activity pressure on providers and reduction in funding in real terms **IMPACT** availability of and access to patient services are significantly reduced	4	• BCT programme established to reconfigure health economy across LLR • WLCCG medium term draft plan submitted 11th September 2015	• BCT Board meetings attending by Managing Director • PMO monitors implementation of year 1 actions and reports to BCT Board • CFO / DF meetings monthly	5	20 (R) ⟷	• Implementation of year 1 project actions • Source of transitional funding to be secured to enable change to take place in future years • Implementation/Contractual Agreement of Bed Reconfiguration phase 1 • Finalising Pre-consultation Business Case prior to November Consultation, including impact of consultation options and refresh of 5 year financial outlook • NHS England approval for start of consultation process	Oct-15
2.1	3a, 3b, 3c and 3d	Spencer Gay (CFO)	**RISK** That the CCG fails to delivery its stautory duty to breakeven over the 5 year planning period **CAUSE** Over-performance by providers, under-delivery of QIPP, over spend in medicines management costs **IMPACT** The CCG is placed in special measures	4	• 5 year plan developed March 2014. • Balanced financial plan in place for 2015/16. • Refreshed 3 Year Plan produced in 15/16 Q2.	• Finance Sub Group for review of plan and monitoring of performance • Board for review of plan and monitoring of performance	3	12 (A) ⟷	• Investigate oppurtunities to reduce risk through fixed contract values • Review QIPP schemes for feasibility & monitor achievement • Ensure consistancy of QIPP with BCF and BCT programmes • Focus to ensure sufficient QIPP in pipeline from 16/17 and beyond.	Oct-15