Bristol, North Somerset and South Gloucestershire Clinical Commissioning Group

NHS 70 YEARS OF THE NHS 1948 - 2018

Meeting of Governing Body

Date: Tuesday 2nd October 2018
Time: 1.30pm
Location: The Vassall Centre, Gill Avenue, Downend, BS16 2QQ

Agenda number: 9.1

Report title: Governing Body Assurance Framework and Corporate Risk Register

Report Author: Sarah Carr, Corporate Secretary and Laura Davey, Corporate Manager
Report Sponsor: Sarah Truelove, Deputy Chief Executive and Chief Finance Officer

1. Purpose

This report provides the Governing Body with the Governing Body Assurance Framework (GBAF) for review and an overview of the current position of the high level risks within the organisation. The report provides an update on the development and monitoring of these high level risks as recorded on the Corporate Risk Register and invites further discussion on the risks shown.

2. Recommendations

The Governing Body is asked to:

- Receive and discuss the Corporate Risk Register
- review and comment on the GBAF, the risks, controls, assurances and mitigating actions identified

3. Executive Summary

The Corporate Risk Register for October 2018 is attached at Appendix 1. The Risk Register provides assurance to the Executive Team, Audit, Governance and Risk Committee, Strategic Finance Committee and the Governing Body that any high level risks are being addressed and that the actions taken are appropriate. Where a risk is linked to one or more of the CCGs principle objectives this is identified on the risk register. Highlights of the risk register can be found below.

	1-3	4-6	8-12	15-25	Total
Commissioning			2	6	8
Transformation		7	9		16
Finance	5	1	5	1	12
Area Teams		11	18		29
Nursing and Quality		2	7	2	11
Medical Directorate Primary Care and Commissioning			15		15

Medical Directorate Clinical Effectiveness			12	2	14
Total	5	21	68	11	105

All risks within the Corporate Risk Register have been discussed at the Strategic Finance Committee on 25 September 2018, Audit, Governance and Risk Committee on 26 September 2018 and at the Quality committee on 20 September 2018.

At its seminar session in June 2018 the Governing Body reviewed the CCG priority areas, looking at the critical issues to be addressed during the CCG's first months of operation. Eight priorities were identified as principal objectives and through discussion the associate principal risks were outlined. These principal risks were further refined by the Executive Directors, who populated the CCG Governing Body Assurance Framework. The Governing Body approved the GBAF, the principal objectives and risks, controls, sources of assurance and mitigating actions to address gaps in controls and/or assurances at its July meeting. Subsections of the GBAF have been received and reviewed at the relevant committee meetings, in line with the CCG Risk Management Framework.

For each principal objective the principal risk is described, and the lead Director and the date of the last review highlighted. The controls for each risk and further mitigating actions are set out. The assurances available are described and any gaps in assurance identified. Lead directors are responsible for ensuring that risks are updated monthly, reviewing the impact of actions in place and identifying further actions as required. Each principal risk is monitored and reviewed monthly by a relevant committee of the Governing Body or, if appropriate, the executive team. The committees monitor the risks and gain assurance regarding the progress of mitigating actions and the closing of any gaps in assurance.

4. Financial resource implications

As part of the Risk Management Strategy the risk register and the GBAF are used to identify the impact of risks including financial risks.

5. Legal implications

There are no legal implications anticipated in relation to this report.

6. Risk implications

The GBAF highlights risks to the CCG's principal objectives. The Corporate Risk Register shown at appendix 1 shows the current position of the high level risks faced by the organisation.

7. Implications for health inequalities

No health inequalities issues arise as a result of this report, and there is no impact upon people with protected characteristics.

8. Implications for equalities (Black and Other Minority Ethnic/Disability/Age Issues)

No health inequalities issues arise as a result of this report, and there is no impact upon people with protected characteristics.

9. Implications for Public Involvement

Not applicable to this report.

Appendices:

Appendix 1 – Corporate Risk Register – October 2018
Appendix 2 – Governing Body Assurance Framework

Bristol, North Somerset and South Gloucestershire Clinical Commissioning Group

BNSSG CCGs Governing Body Assurance Framework

Governing Body Assurance Framework risk tracker

The Governing Body Assurance Framework identifies the BNSSG CCGs' principal, strategic objectives and the principal risks to their delivery. The controls in place to manage those identified risks are summarised. The internal and external assurances that controls are in place and have the impact intended are set out. Where there are gaps in controls or assurances these are described and the actions planned to mitigate these gaps are explained. The table below gives an overall summary of the Governing Body Assurance Framework. The detailed framework is at page 3

Risk Tracker	Lead Director	Initial Risk score	Current risk score	Risk appetite	Trend	Gaps in controls/ assurance
Principle Objective PO1: Develop Organisational Development plan						
Principle Risk: If the right organisational structure, culture, behaviours and skills are not developed we may not be able to deliver our objectives	Sarah Truelove	**5x4= 20**	**4x4 =16**	**3x4 =12**		yes
Principle Objective PO2: Develop a Solution for Weston Hospital within BNSSG						
Principle Risk: If we are unable to work with key stakeholders to engage own a solution for Weston Hospital the consultation will fail	Sarah Truelove	**5x5= 25**	**4x5=20**	**2x5=10**		no
Principle Objectives PO3: Financial Recovery						
Principle Risk: If we do not deliver the full required savings there will be an impact on financial recovery and the CCGs credibility.	Sarah Truelove	**5x5= 25**	**4x5=20**	**2x5=10**		yes
Principle Objective PO4: Building the System with our providers						
Principle Risk: If we can't agree a process to gain agreement to a single budget across BNSSG for 2019/20 we can't deliver a genuine single plan	Julia Ross/Sarah Truelove	**5x4= 20**	**4x4= 16**	2x2=8		yes
Principle Objectives PO5: A&E Recovery						
Principle Risk: Risk of failure to recover A&E performance, which has wider implications due to the potential for patient harm and organisational reputation	Lisa Manson	**5x4= 20**	**4x4 =16**	**3x4 =12**		yes
Principle Objectives PO6: Plan Community Procurement						
Principle Risk: balancing the need for pace with the need to scope, specify and initiate the procurement of community services, results in sub-optimal results, and generates unstable services in 19/20	Lisa Manson	**4x4= 16**	**3x4=12**	**3x3=9**		no

Principle Objectives PO7: Stabilisation and Improvement of Core Mental Health provision						
Principle Risk: If our core mental health provider is not stable and effective there is a risk of harm to patients, an excessive burden on the wider system and a poor experience for our population and their families	Deborah El-Sayed	**4x5=20**	**4x5=20**	**2x5=10**	⇔	yes
Principle Objectives PO8: Locality Development						
Principle Risk: if there is insufficient capacity and capability to develop and deliver integrated community localities, the BNSSG system will not have the necessary building blocks in place for delivery of the system wide transformation required	Justine Rawlings David Jarrett Colin Bradbury	**4x4=16**	**3x4=12**	**3x3=9**	⇓	yes

The CCG risk scoring matrix as set out in the Risk Management Framework is:

Risk Assessment scoring matrix

likelihood of happening	Insignificant = 1	Minor = 2	Moderate = 3	Major = 4	Catastrophic = 5
Almost certain = 5	5	10	15	20	25
likely = 4	4	8	12	16	20
possible = 3	3	6	9	12	15
unlikely = 2	2	4	6	8	10
Rare = 1	1	2	3	4	5

Impact

<table>
<tr><td>Objective: Develop OD Plan</td><td>Director Lead: Sarah Truelove</td></tr>
<tr><td colspan="2">Risk: If the right organisational structure, culture, behaviours and skills are not developed we may not be able to deliver our objectives
Date Last Reviewed: September 2018</td></tr>
<tr><td>Risk Rating (Likelihood x impact)
Initial: 5x4=20
Current: 4x4=16
Appetite: 3x4=12</td><td>Rationale for current score:
There were 3 different ways of doing things across the former CCGs. We are now establishing systems both formal/informal, and identifying gaps in the organisation. Work on the organisation culture is yet to start, and there is a gap between vision and delivery of strategy.</td></tr>
<tr><td>Committee with oversight of risk
Executive Team</td><td>Rationale for risk appetite: OD is a long term process and there is an element of residual risk for the six month period.</td></tr>
<tr><td rowspan="2">Controls: (What are we currently doing about this risk?)
Training Budget established
OD plan shared in draft with Governing Body and SMT
New accommodation in place
Governance structures and Committee Terms of Reference agreed
New organisation established
Single IT Domain
Chief Exec weekly stand-ups in place
Flexible working policy agreed
Staff partnership forum in place
Whole staff event held on values and behaviours
The Hub has been updated and is now the home page for all staff
Mitigating Actions: (what further actions are needed to reduce the risk and close any identified gaps)
Expertise to be recruited to further develop the OD plan
Appraisal Policy to be agreed
Performance Management Policy to be agreed
Internal Communications plan to be further built on and implemented
Workforce report being developed for Governing Body
Further work with staff to develop values
Leadership Programme for all clinical leads and SMT under development</td><td>Assurances:
Staff survey reports
360 survey reports</td></tr>
<tr><td>Gaps in Assurance: (What additional assurances should we seek?)
Workforce report to Governing Body</td></tr>
<tr><td>Current Performance: (With these actions taken, how serious is the problem?)</td><td>Additional Comments:</td></tr>
</table>

Objective: Develop a Solution for Weston Hospital within BNSSG	**Director Lead: Julia Ross / Katie Norton**
Risk: If we are unable to work with key stakeholders to engage own a solution for Weston Hospital the consultation will fail	**Date Last Reviewed: September 2018**
Risk Rating *(Likelihood x Impact)* Initial:5x5=25 Current:4x5=20 Appetite: 2x5=10	**Rationale for current score:** New governance arrangements in place and aligned to STP from June 2018 to support engagement of key stakehodlers
Committee with oversight of risk **Commissioning Executive**	**Rationale for risk appetite:** A solution for Weston Hospital is a key element of CCG Strategy
Controls: • Healthy Weston Steering Group and Programme Governance established • Regular reports to North Somerset Health Overview and Scrutiny Panel • Joint BNSSG Health Overview and Scrutiny Committee (HOSC) and Somerset HOSC; • 6 weekly meetings with NHS England and South West Senate • As appropriate reports received by Strategic Finance Committee and Commissioning Executive. • Commissioning context published • Programme architecture designed to ensure strong provider and clinical ownership of preferred solution/s • **Additional specialist resource procured to support the clinical design and options development** • **Programme governance embedded**	**Assurances:** • Regular item on Governing Body seminar agenda to ensure fully sighted on Programme plan and progress with particular focus on provider engagement • NHSE Gateway Checkpoints reported to Governing Body • Governing Body will have formal role in signing off: - Evaluation criteria for long list and short list - Pre-consultation Business Case, which will evidence clinical ownership and provider advocacy - Consultation document and consultation plan
Mitigating Actions: *(what further actions are needed to reduce the risk and close any identified gaps)* • **Procurement of additional specialist support for consultation and engagement**	**Gaps in Assurance:**

Current Performance:	Additional Comments:
• **Case for change and evaluation criteria to be received by Governing Body October 2018** • **Progress on track regarding options development**	While recognising the key objective is to develop a solution for Weston Hospital and achieve a successful public consultation that enables changes to secure a clinically and financially sustainable future for Weston General Hospital, Healthy Weston has developed a wider remit through the co-design work. The Programme has proposed an approach which will ensure that those opportunities not directly linked to the Weston Hospital Health and Care Campus vision are progressed in parallel.

Objective: Financial Recovery	**Director Lead: Sarah Truelove**
Risk: If we do not deliver the full required savings there will be an impact on financial recovery and the CCGs credibility.	**Date Last Reviewed: September 2018**
Risk Rating *(Likelihood x impact)* Initial: 5x5=25 Current: 4x5=20 Appetite: 2x5=10	**Rationale for current score:** There is a system history of previous financial deficits. The CCG has recently moved from 'special measures'. Currently risk assessed savings plans leaving unidentified savings 2018-19. Previous years have seen a dependence on transactional savings. The CCG is in year one of a three-year recovery plan.
Committee with oversight of risk **Strategic Finance Committee**	**Rationale for risk appetite:** Long term system financial recovery is a primary objective with a focus on whole system cost reduction a key driver. Behaviours and developing trust across the system will be an important factor and will take time therefore there is a residual risk over the six month period.
Controls: *(What are we currently doing about this risk?)* • Financial Plan including risks and mitigations in place • PMO approach established and in place • Control Centre approach established and in place • Turnaround steering Group established • Monthly reporting to Strategic Finance Committee • STP Task and Finish Groups established System Delivery Oversight Group providing oversight • Information sharing in place between Healthier Together PMO and CCG PMO • **Control Centre Reviews completed** **Mitigating Actions:** *(what further actions are needed to reduce the risk and close any identified gaps)* • Targeted communication to practices about practical things they can do eg over the counter medicines – **this is ongoing with further action to reduce wider practice variation** • Provide more feedback to clinicians about schemes that are going well and performance • System wide financial reports to come to the Strategic Finance Committee and to be reported in minutes to Governing Body • **Improve internal communications to share position and best practice** • **Further training from PMO and budget holder training**	**Assurances:** • Internal audit report on savings plans and PMO processes • QIPP stage 3 process carried out by NHS England • Monthly Governing Body reports • Quarterly NHSE Assurance meetings • QIPP Stage 4 Support to Urgent Care • 95% delivery to month 5 and improving forecast outturn **Gaps in Assurance:** *(What additional assurances should we seek?)* • Strategic Finance Committee does not receive system wide financial reports and therefore not included in minutes to Governing Body

Current Performance: *(With these actions taken, how serious is the problem?)* **Risk assessed position is currently £27m against a £37m plan (as at month 3).**	**Additional Comments:** **System financial position is being collated by the STP for Month 3 performance and has been included on the July SFC agenda**

Objective: Building the System with our providers	**Director Lead: Julia Ross/Sarah Truelove**
Risk: If we can't agree a process to gain agreement to a single budget across BNSSG for 2019/20 we can't deliver a genuine single plan	**Date Last Reviewed: June 2018**
Risk Rating *(Likelihood x impact)* Initial:5x4=20 Current:4x4=16 Appetite:2x2=4	**Rationale for current score:** High likelihood because there is no systematic or structured process currently in place, this is a challenging goal to land and delivery timeframes are tight. If the risk materialises it will have a major impact both reputational and in our ability to deliver a system financial recovery plan to enable service transformation and long term sustainability BNSSG is a complex system with significant out of area flows and national no work has covered a similar system.
Committee with oversight of risk **Executive Team**	**Rationale for risk appetite:** We want to maximise our opportunity to achieve a single budget and plan for 2019/20 whilst recognising that to do so requires significant cultural and leadership shift. It is important therefore to focus on reducing the potential impact as well as the likelihood
Controls: STP governance in place including: • Chairs' Reference Group • STP Sponsoring Board • Executive Group • System Delivery Oversight Group Directors of Finance meeting • Clinical Cabinet • Regular discussion at executive team • Commitment to single system planning and broad ambitions from Chief Exec group August 2018 **Mitigating Actions** *(what further actions are needed to reduce the risk and close any identified gaps)* • Establish a structured process and delivery plan with key milestones • Commission external facilitation to provide appropriate challenge in the system • Utilise the STP Chairs' Reference Group and potentially offer an Audit Chairs' workshop to address the governance issues • Gain shared clarity about the end point and assure alignment by drafting a paper for all Boards outlining the logic model and benefits of a single budget and plan, and acknowledging the risks and challenges for individual organisations and how these might be mitigated.	**Assurances:** • Demonstrate understanding of the barriers and how they are being addressed • NHSE/I feedback about the STP and the planning process reported to Governing Body • Healthier Together quarterly reports to Governing Body **Gaps in Assurance:** *(What additional assurances should we seek?)* • Confirmed agreement to the process from each constituent member board

• Ensure broad engagement of CCG Members and Local Authorities to secure stakeholder support • Establish a contingency plan for bilateral plans that deliver a level of system working, building on the UEC Task & Finish Groups approach • System wide planning workshop planned for October 2018 • Aspirant ICS programme will support development of governance	
Current Performance: *(With these actions taken, how serious is the problem?)*	**Additional Comments:**

Objective: A&E Recovery	**Director Lead: Lisa Manson**
Risk: Risk of failure to recover A&E performance, which has wider implications due to the potential for patient harm and organisational reputation	**Date Last Reviewed: July 2018**
Risk Rating *(Likelihood x impact)* Initial: 5 x 4 = 20 Current: 4 x 4 = 16 Appetite: 3 x 4 = 12	**Rationale for current score:** Whilst harm to patients is low risk, risks remain relating to demand for urgent resources / financial risks / A&E recovery; there is a reputational risk in relation to BNSSG 4 hour performance
Committee with oversight of risk **Commissioning Executive**	**Rationale for risk appetite:** Relatively high risk appetite due to labile nature of performance and multiple factors that impact on it
Controls: *(What are we currently doing about this risk?)* • Implementation of National Early Warning Score (NEWS) across all providers. • Monitoring of infection control outbreaks on daily basis • Quality assurance visits undertaken by CCG Quality Team • Twelve Hour Trolley Breach Reporting Process in place. • Emergency Department Safety Checklist in place and reviewed at monthly quality meetings. • Serious incident Reporting Process in place • Contact Us in place for receipt of feedback including complaints from patients and health professionals • Monthly performance and clinical review meetings held with providers focusing on harm to patients and reported to quality committee • Monthly monitoring of patient experience through friends and family test • Contractual systems in place to monitor and manage performance through ICQPM • Shared system-wide diagnostic to inform task and finish groups • Partnership engagement in BNSSG-wide system architecture to support urgent care performance • Agreed system-wide trajectories for A&E performance recovery • Effective system-wide winter plan and regular reporting on it • Urgent Care governance structure established • Urgent care dashboard reviewed at monthly Quality & Performance Committee meetings. • Reporting through Commissioning Executive on sentinel performance metrics to assure recovery • Urgent care dashboard reviewed at monthly Quality & Performance Committee meetings. • Reporting through Commissioning Executive on sentinel performance	**Assurances:** • Governing Body receives monthly quality and performance report and minutes of Commissioning Executive and Quality Committee • Governing Body receives Healthily Together Reports • Quarterly NHSE review meetings and NHSE Improvement and Assurance framework **Gaps in Assurance:** *(What additional assurances should we seek?)* • Visibility of system wide workforce information across primary and secondary care within reports to Governing Body • Review of Urgent Care Oversight Board terms of reference in relation to delivery of urgent care strategy • Visibility at Governing Body of the outcomes of actions implemented following review of issues

metrics to assure recovery • Urgent Care dashboard reviewed at Commissioning Executive • • **Mitigating Actions:** *(what further actions are needed to reduce the risk and close any identified gaps)* • Planned Implementation of Quality Improvement Board and implementation of Serious Incident Learning Events to support the delivery of improvements in performance and quality • Develop urgent care strategy to an agreed system-wide programme of work for 2-5 years • Engagement and action from all parties through application of growth funding to support schemes that manage demand and reduce length of stay in 2018/19 • Review of Urgent Care governance structure to ensure greater visibility of issues	
Current Performance: *(With these actions taken, how serious is the problem?)* June '18 - Available evidence is that harm to patients arising from demand for emergency services is low **July 2018 –** • **On target with trajectory** • **Implementation of out of hospital schemes underway to reduce admissions and length of stay**	**Additional Comments:**

<table>
<tr><td>Objective: Plan Community Procurement</td><td>Director Lead: Lisa Manson</td></tr>
<tr><td colspan="2">Risk: balancing the need for pace with the need to scope, specify and initiate the procurement of community services, results in sub-optimal results, and generates unstable services in 19/20.

Date Last Reviewed: Sept 2018</td></tr>
<tr><td>Risk Rating (Likelihood x impact)
Initial:4 x 4=16
Current:3 x 4=12
Appetite: 3x3=9</td><td>Rationale for current score: The programme of work has just started, so the development of the programme is allowing mitigations of risks to be developed and built into the programme.</td></tr>
<tr><td>Committee with oversight of risk
Commissioning Executive</td><td>Rationale for risk appetite: The CCG needs to re-procure community services in Bristol due to the risk of competition challenge as the services haven’t be market tested previously. This therefore presents the opportunity to recommission consistent community services BNSSG wide hence moderate rating</td></tr>
<tr><td rowspan="3">Controls: (What are we currently doing about this risk?)
Due diligence and scoping exercise completed
Appointment of experienced legal advisors to support the development of the process
Programme Board established
Clinical Reference Group in place
Reporting through to Strategic Finance Committee and Commissioning Executive
The SFC has oversight of the procurement process and the financial evaluation.
Commissioning Executive has sign off the evaluation criteria and specification
Clear reporting arrangements across the CCG and briefing to STP Execs
Engagement with localities and membership on scope of specification
Mitigating Actions: (what further actions are needed to reduce the risk and close any identified gaps)
From the due diligence develop a series of metrics to monitor and review the extant providers
service specification in development with arrangements to full</td><td>Assurances:
A full governance programme has been established which links through from localities to the Governing Body.
Governing Body receives minutes of the Strategic Finance Committee and the Commissioning Executive</td></tr>
<tr><td></td></tr>
<tr><td>Gaps in Assurance:</td></tr>
</table>

engagement with stakeholders • **Due Diligence and Scope to be approved at Governing Body Oct 18** • **Service Specification to be agreed at Commissioning Executive Nov 2018**	
Current Performance: *(With these actions taken, how serious is the problem?)* • **Programme on target**	**Additional Comments:**

<table>
<tr><td>Objective: Stabilisation and Improvement of Core Mental Health provision</td><td>Director Lead: Deborah El-Sayed</td></tr>
<tr><td colspan="2">Risk :If our core mental health provider is not stable and effective there is a risk of harm to patients, an excessive burden on the wider system and a poor experience for our population and their families

Date Last Reviewed: July 2018</td></tr>
<tr><td>Risk Rating (Likelihood x consequence)
Initial: 4x5 =20
Current: 4x4=20
Appetite:3x5= 15</td><td>Rationale for current score: There are ambitious joint plans in place across our provider and the CCG. However this is a complex multi- factoral challenge covering out STP and neighbouring STP in BSW. The high likelihood remains as plans are yet to deliver tangible benefits. This is being tracked and supported by the CCG to help enlist a whole system response</td></tr>
<tr><td>Committee with oversight of risk
Commissioning Executive</td><td>Rationale for risk appetite: The complexity of the challenge means the expected impact is likely to take time and be one of incremental improvement and stabilisation during the 6 month time frame</td></tr>
<tr><td rowspan="2">Controls:
Regulator defined KPIs including financial balance via Contract Quality and Performance Meeting (CQPM) BNSSG and BSW and the PCE (BNSSG) only.
Patient Safety actively managed by Quality Committee sub group
Strategic Finance Committee engaged and kept informed of control centre and SDOG activity
Mental Health embedded in all STP work-streams
Shared Leadership Development (commenced in May 2018)
Quarterly Report to Commissioning Exec
Mitigating Actions:
Joint working with BSW
Joint Planning and delivery of the Estates Project
Multi Agency Section 136 project
Joint Technology improvement plan
AWPs transformation programme
Driving forward the work of the Integrated Mental Health Strategy Framework to focus on prevention and defining optimal service provision that is more reflective of the needs of our population and how they present to services
Development of lead indicators to close gap in assurance</td><td>Assurances:
Close joint working of the CCG and AWP executive teams - via regular Board to Board meetings
Commissioning Executive minutes received at Governing Body</td></tr>
<tr><td>Gaps in Assurance:
Define the lead indicators including patient reported measures and reports from primary care localities. This will show progress on the specific measurement of stabilisation and improvement that are currently not well served by the regulators KPIs – to be closed by Autumn 2018</td></tr>
</table>

Current Performance: These activities are all in progress there has been insufficient impact as at June 2018 to warrant a reduction in the risk rating.	**Additional Comments**

Objective: Locality Development	**Director Lead: Area Directors**
Risk: if there is insufficient capacity and capability to develop and deliver integrated community localities, the BNSSG system will not have the necessary building blocks in place for delivery of the system wide transformation required	**Date Last Reviewed: June 2018**
Risk Rating *(Likelihood x impact)* Initial: 4x4=16 Current: 3x4=12 Appetite: 3x3=9	**Rationale for current score:** GP provider localities and relevant relationships are very new and need to develop maturity to be part of a wider provider alliance.
Committee with oversight of risk **Commissioning Executive**	**Rationale for risk appetite:** this is a developing model of working and so an element of residual risk is likely for the 6 month period across the 6 localities
Controls: • Locality Transformation Scheme plan and agreed transfer of funds based on achievement of key milestones • IA specification and sign off via PCOG and contract • Integrated working template and sign off via Integrated care steering group **Mitigating Actions:** *(what further actions are needed to reduce the risk and close any identified gaps)* • Significant engagement and support to locality providers in developing plans • Locality provider forums to support emerging leaders • CEO meetings with community and other providers • Alignment through LLG of plans • One Care partnership • Broader membership engagement and practice visits • Development of narrative via STP event • Phase three Locality Transformation Plan to be developed • PPI plan to link to STP	**Assurances:** • Reports to Governing Body regarding LTS plan and • Regular STP report to Governing Body • 360 degree survey report to Governing Body **Gaps in Assurance:** • Stronger and regular reporting to the Governing Body
Current Performance: *(With these actions taken, how serious is the problem?)*	**Additional Comments:**

BNSSG CCG Corporate Risk Register 2018-19

The Corporate Risk Register identifies the high level risks (15+) within the CCG. It sets out the controls that have been put in place to manage the risks and the assurances that have been received that show if the controls are having the desired impact.
The Corporate Risk Register is received by the Governing Body 6 Monthly, by the Audit Governance and Risk committee Quaterly and by the executives bi-monthly.
Risk is assessed by multiplying the impact/Severity of a risk materialising by the likelihood/probability of it materialising using the risk assessment matrix set out in the CCG Risk Management Strategy .
Risks are also mapped against the CCG risk appetite and accepted risk limits to provide an indicative acceptable risk level. Where a risk maps to more than one principal objective the lowest level of risk appetite and risk limit is given. It is for the Governing Body to decide if these risk limits are appropriate for each individual risk

										Risk Rating						
Directorate or Project	Risk Ref	Principle Objective Ref	Date Logged	Description of Risk *As a result of …* *There is a risk that …* *Which may result in ...*	Mitigating Actions	Progress on Actions	Gaps in Mitigating Actions	Committee Responsible for Revieing	Director	Risk Owner (for Updates)	Initial Risk (PxS)	Current Risk (PxS)	Movement of current risk	Residual (Target) Risk (PxS)	Target date for completion of actions	Risk open or closed (If closed specify date)	Last reviewed
Medical Directorate Primary Care Commissioning	MDPCC12	N/A	13/08/2018	There is a risk to access to primary care and to system resilience if general practice sustainabiity is not addressed.	Primary Care Strategy Primary Care Commissioning Committee responsible for developing and improving General Practice. Locality Transformation Scheme in place to support collaboration and transformation in primary care. Investment in GP Forward View (GPFV) including use of resilience funds.	Approach to primary care resilience presented to and supported by PCCC in May 2018. Locality provider groups have submitted proposals for phase 2 of the Locality Transformation Scheme. Plans for use of GPFV reseilience funds submitted to NHSE in July 2018. Project mandate in development for General Practice resilience and transformation workstream as part of STP.	There is a range of work required by the CCG, practices, NHSE nationally and local stakeholders including One Care Ltd., Community Education Provider Network (CEPN) and Avon LMC to support the sustainability of practices in BNSSG. The STP workstream will draw together local stakeholders to develop concerted action.	Primary Care Commissioning Committee (PCCC)	Martin Jones	Jenny Bowker	16 (4x4)	12 (3x4)	↓	8 (2x4)	Mar-19	Open	Aug-18
Nursing & Quality	BNSSG QD 001	D2	13/04/2015	Cancer patients are at risk of potential harm if there are delays in the cancer pathway	Clinical validation of waiting lists completed by providers and reviewed by the CCG Quality team monthly Where providers identify potential harm CCGs require evidence of mitigating actions	Further mitigating actions require system wide focus on cancer pathway Jan 2018 - Focusing on a system wide focus on cancer pathways for over 18 months . Monthly performance meetings held with individual Trusts. NBT are consistently achieving the target, UHB and Weston have robust, jointly agreed remedial action plans in place which are monitored closely. UHB achieved the target in November and despite a lapse in December have met trajectory and hope to achieve the target for the quarter. In addition there are monthly breach meetings with all three cancer managers to review breaches, review validation processes, identify issues and put actions into place. Potential harm is assessed through reporting and discussion. Current priority pathways for review and transformation work are colorectal, lung and prostate. This work is being carried	none identified currently; monitoring of position continuing	Quality Committee	Anne Morris	Cecily Cook	20 (4x5)	15 (3x5)	↓	10 (2x5)	31/03/2019	Open	Sep-18
Nursing & Quality	BNSSG QD 002	D2	13/04/2015	Patients are at risk of potential harm through contracting HCAIs	Quality dashboard reviewed at monthly quality and governance committee Monthly performance and clinical quality review meetings held with providers and reported to Quality and Governance Committee Detailed analysis of CCG apportioned individual MRSA cases and GP review of primary care C Diff cases Bi-monthly BNSSG HCAI meeting with partner organisations to monitor and support HCAI improvements. Separate Task and finish groups established for MRSA, C diff and E.coli infections close joint working in place with Public Health colleagues regular quality assurance visits undertaken by CCG Quality team	Monthly meetings held with individual Trusts to review C.difficile cases. All acute Trusts are below objective set by NHS England Visit undertaken to NBT in October 2017 with NHSI to review infection control practice. Positive assurance gained. Jan 2018 - Observational visits planned to be undertaken at Weston General and Callington Road Hospitals as experiencing Norovirus. Daily infection sitrep in place during Norovirus outbreaks and review of Trust procedures to control and reduce infection.BNSSG working group to reduce E.coli bacteraemia is working towards a single catheter passport. MRSA task and finish group is reviewing 2014 action plan and updating actions to reduce MRSA in intravenous drug users April 2018. Infection control visit to Weston General Hospital completed 10 April 2018. Positive assurance gained End of	none identified currently; monitoring of position continuing	Quality Committee	Anne Morris	Cecily Cook	20 (4x5)	15 (3x5)	↓	5 (1x5)	31/03/2019	Open	Sep-18
Nursing & Quality	BNSSG QD 014	D2	22/06/2018	The diabetic foot pathway at WAHT is currently experiencing capacity issues resulting in some patients not receiving access to a suitable pathway within 48hrs. Delays in this pathway increase the risk of harm to diabetic patients with complications related to peripheral vascular disease and or autonomic neuropathy	Referrals triaged by Weston Diabetic Consultant with patients seen within 48hrs at MDT clinic. MDT Clinics are not daily, therefore an SOP is in place for either direct admission under care of acute medical team or direct referral to vascular team at NBT is in place.	WAHT providing update to Quality Sub Group on a monthly basis re number of patients assessed/referred via the pathway as well as ongoing capacity of the MDT clinic. NSCP Podiatrist keeping a log of ongoing issues.	WAHT & NSCP have not supplied figures regarding SOPs use. WAHT have not signed the SOP agreement.	Quality Committee	Anne Morris	Cecily Cook	16 (4x4)	12 (3x4)	↓	4 (1x4)	31/03/2019	Open	Sep-18
Medical Directorate - Clinical Effectivness	M01	PO3	08/08/2018	As a result of NCSO & CAT M - There is a risk of overspending on allocated drugs budget due to NCSO and Category M inflations in year - impact of NCSO will continue to be a problem, after April having few drugs on list, May has increased. Also those drugs that were on the NCSO list that have now been removed from the list have come back into category M part of drug tariff at a much higher price. This is being monitored on a monthly basis - but annual estimates risk in region of £4m.	Will review drugs on the NCSO list and highlight to prescribers any alternatives where possible. Continue with savings plans to mitigate impact on total spend	Monthly monitoring accounts for additional costs of £200k (May) & £240k (June).	Often there are no alternatives available.	TBC	Peter Brindle	Debbie Campbell	20 (5x4)	20 (5x4)	=	TBC	TBC	Open	Sep-18
Medical Directorate - Clinical Effectivness	MO2	PO3	08/08/2018	As a result of Category M price increases from Aug 2018. There is a risk that a cost pressure of approximately £300,000 per month could be realised for BNSSG CCG. (Figures to be reviewed again before October Tariff) Which may result in difficulty remaining within pre determined budget.	Nationallly implemented so with little control, will seek options for prescribing alternatives wherever possible.		Often there are no alternatives available.	TBC	Peter Brindle	Debbie Campbell	20 (5x4)	20 (5x4)	=	TBC	TBC	Open	Sep-18

Medical Directorate - Clinical Effectivness	MO10	PO1	08/08/2018	BI support to Medicines Optimisation Programme is compromising ability to have performance data for practices and highlight prescribing area's to focus. -This is due to new ePACT2 (New prescribing data system) system knowledge of functionality and requiring reports to be produced. -Volume of work required is greater. -Lack of capacity with in BI (reliant on one member of staff)	Discuss with new associate director. Using medicines optimisation pharmacist to produce some of the data required.	Another person is being trained in use of EPACT2		TBC	Peter Brindle	Debbie Campbell	16 (4x4)	16 (4x4)	=	TBC	TBC	Open	Sep-18
Comissioning Directorate	1	PO1	10/08/2018	There is a risk that the if commissioning element of the organisational structure, culture, behaviours and skills are not developed we may not be able to deliver our specific objectives	Directorate 'away day' to establish culture behaviour and skills associated and mirror organistaional OD plan. Ensure there are quarterly directorate meetings to ensure effective channels of communication between CLT (commissioning leadership team) and the wider team. Implementation of the fexible working policy across the directorate. Ensure representation on the Joint Consultative Committee. Ensure staff have opportunities for regular 1:1's with their line manager. Setting clear objectives for all staff and undertake regular appraisal meetings.	To be reviewed at CLT monthly	TBC	Commissioning Leadership Team / Commissioning Executive	Lisa Manson	Emma Moody	20 (5x4)	16 (4x4)	↓	TBC	TBC	Open	Aug-18
Comissioning Directorate	2	PO2	10/08/2018	If we are unable to work with key stakeholders to commission a sustainable solution for Weston Hospital the consultation will fail	Ongoing engagement with Weston through Whole System Operational Group. Ensure there is commissioning involvement in the development of the Healthy Weston approach.	To be reviewed at CLT monthly	TBC	Commissioning Leadership Team / Commissioning Executive	Lisa Manson	Sarah Swift	25 (5x5)	20 (4x5)	↓	TBC	TBC	Open	Aug-18
Comissioning Directorate	3	PO3	10/08/2018	If we do not deliver the full required savings from the control centres within the commissioning directorate there will be an impact on the wider CCG financial recovery and subseqently the CCGs credibility.	Engagement with providers through the control centre process to identify and implement system savings.	To be reviewed at CLT monthly	TBC	Commissioning Leadership Team / Commissioning Executive	Lisa Manson	Claire Thompson	25 (5x5)	20 (4x5)	↓	TBC	TBC	Open	Aug-18
Comissioning Directorate	4	PO4	10/08/2018	If we can't agree a process to gain agreement to a single budget across BNSSG for 2019/20 we can't deliver a genuine single plan	Ensure commissioning processes are in line with the proposed single budget plan across BNSSG. Commissioning involvement in system planning.	To be reviewed at CLT monthly	TBC	Commissioning Leadership Team / Commissioning Executive	Lisa Manson	TBC	20 (5x4)	16 (4x4)	↓	TBC	TBC	Open	Aug-18
Comissioning Directorate	5	PO5	10/08/2018	Risk of failure to recover A&E performance, which has wider implications due to the potential for patient harm.	Contractual systems in place to monitor and manage performance through ICQPM's Hospital focussed improvement programmes System Management call process and procedure being further refined and developed. Partnership engagement in BNSSG-wide system architecture to support urgent care performance Urgent Care governance structure established Monthly review of urgent care dashboard's at a system level (A&E delivery board) to determine A&E performance and associated areas for improvement Ongoing monitoring of patient harm through existing CCG quality governance	To be reviewed at CLT monthly	TBC	Commissioning Leadership Team / Commissioning Executive	Lisa Manson	Julie Kell	20 (5x4)	16 (4x4)	↓	TBC	TBC	Open	Aug-18
Comissioning Directorate	6	PO6	10/08/2018	Balancing the need for pace with the need to scope, specify and initiate the procurement of community services, results in sub-optimal results, and generates unstable services in 19/20	From the due diligence develop a series of metrics to monitor and review the extant providers Develop service specification ensuring full engagement with stakeholders Build on learning from previous procurements. Clear reporting arrangements across the CCG and briefing to STP Execs.	To be reviewed at CLT monthly	TBC	Commissioning Leadership Team / Commissioning Executive	Lisa Manson	Rachel Anthwal	16 (4x4)	12 (3x4)	↓	TBC	TBC	Open	Aug-18

Comissioning Directorate	7	PO7	10/08/2018	If we are unable to commission a stable and effective mental health provider there is a risk of harm to patients, an excessive burden on the wider system and a poor experience for our population and their families.	□ Multi Agency Section 136 project □ Effective implementation of the mental health strategy. □ Effective contract management processes with the current provider.	To be reviewed at CLT monthly	TBC	Commissioning Leadership Team / Commissioning Executive	Lisa Manson	Emma Moody	20 (4x5)	20 (4x5)	↓	TBC	TBC	Open	Aug-18
Comissioning Directorate	8	PO8	10/08/2018	If there is insufficient capacity and capability to develop and deliver integrated community localities, the BNSSG system will not have the necessary building blocks in place for delivery of the system wide transformation required.	□ Commission sufficent Primary Care capacity	To be reviewed at CLT monthly	TBC	Commissioning Leadership Team / Commissioning Executive	Lisa Manson	David Moss	16 (4x4)	12 (3x4)	↓	TBC	TBC	Open	Aug-18
Fiannce Directorate			21.8.18	Over-performance against planned activity and costs which may result in an unmitigated overspend against the financial plan which may result in failure to meet the control total	Contract monitoring and contract performance management processes CCG processes that support an integrated assessment of activity and costs Systematic review of contract information Contract challenges and dispute resolution	Performance management structures and processes in place Business Intelligence and contract finance teams review contract data sets Formal process for contract challenges and dispute resolution in place and operating	CCG is developing the integration of performance analysis and management		Sarah Truelove	Mike Vaughton	12 (4x3)	16 (4x4)	↑	TBC	31.3.19	Open	Sep-18