Meeting of Governing Body

Date: Tuesday 8th January 2019
Time: 1.30pm
Location: The Weston College, Knightstone Road, Weston-super-Mare, North Somerset, BS23 2AL

Agenda number: 9.5
Report title: Corporate Risk Register and Governing Body Assurance Framework

Report Author: Sarah Carr
Report Sponsor: Sarah Truelove

1. Purpose
This paper presents the Corporate Risk Register (CRR) and the Governing Body Assurance Framework (GBAF) for review, comment and approval.

2. Recommendations
The Governing Body is asked to:

- Review, comment on and note the additions to the Corporate Risk Register and the Governing Body Assurance Framework, and to
- Approve the removal of risks from the Corporate Risk Register where risk scores have been reviewed and reduced
- Approve the review of the Governing Body Assurance Framework, the Principal Objectives and the risks to these for 2019/20 in a future seminar.

3. Executive Summary
The CRR provides assurance to the Governing Body and its committees that all risks scored at 15 and above using the risk scoring matrix are being addressed and that the actions taken are appropriate. A number of risks have been reviewed and revised and the changes are highlighted in the register in **bold blue text.** There have been a number of additions to the CRR since its last review at the October Governing Body meeting:

Nursing & Quality QD 21	Patients are at risk of harm from call incident stacking at SWASFT causing a delay to ambulance response times
Commissioning Directorate 12	Infectious disease outbreak including high consequence infectious diseases. (VHF Ebola / SARS / MERS)

Commissioning Directorate 13	Lack of coordinated response and special measures in the event of a mass casualty incident due to lack of operational plans and training. This increases the likelihood of substandard care and impacts on the health system.
Commissioning Directorate 15	An ineffectual radiation monitoring unit causing loss of public confidence and ineffective monitoring. Would also cause further strain on NHS resources already stretched by the response
Commissioning Directorate 18	National EU Exit (Brexit) • Supply of medicines and vaccines; • Supply of medical devices and clinical consumables; • Supply of non-clinical consumables, goods and services; • Workforce; • Reciprocal healthcare; • Research and clinical networks • Data sharing, processing and access.

The following risks were added to the CRR after the October review and subsequently reviewed and their risk scores reduced.

Area Directorate NS08	There is a risk that the JDI work that come out of the Healthy Weston work is not incorporated in to the wider PCBC process, resulting in a lack of coordination making them less effective.
Area Directorate NS09	There is a risk that the HOSP do not feel engaged in the STP work and the development of the Integrated Care System, resulting in withdrawal of support.
Commissioning Directorate 9	capacity issues regarding the IFR Panel may result in delayed decision making with subsequent impact on patients

The following risk has been reviewed and the risk score reduced to below the threshold for the CRR and it is requested that this risk and the risks above are removed. These risks will continue to be monitored through Directorate Risk Registers. These risks are:

Commissioning Directorate 1	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

The GBAF identifies where there are risks to the CCG's principal objectives, the controls in place to mitigate those risks and the assurances available to the Governing Body that risks are being managed. The GBAF indicates where there are potential gaps in controls and assurances and provides a summary of the actions in place to resolve these gaps. Each risk reported on the GBAF is reported to a specific committee. Each committee reviews its specific risks at its meetings to ensure that the information provided is line with the committee's expectations. All changes to the GBAF are indicated in **bold blue text.**

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. The principal objectives were initially identified as priorities for the first six-months of the CCG's operation. The principal objectives continue to be reviewed by Directors and at the committees of the CCG. The GBAF was reviewed at the December Audit, Governance and Risk Committee and it was noted that the principal objectives were relevant and appropriate and it was agreed to recommend that the Governing Body revisits and reviews the GBAF and the Principal Objectives and the risks to these for 2019/20 in a future seminar.

4. Financial resource implications

Financial risks are reviewed by the Strategic Finance Committee.

5. Legal implications

Legal implications arising from risks are reported on the GBAF and CRR.

6. Risk implications

The CRR and GBAF are part of the CCG's risk management framework.

7. Implications for health inequalities

Where there are implications for health inequalities these are reported on the CRR and GBAF.

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

Where there are implications for inequalities these are reported on the CCR and GBAF.

9. Implications for Public Involvement

Where there are implications for Public Involvement these are reported on the CRR and GBAF.

BNSSG CCG Corporate Risk Register 2018-19 Dec 2018

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 Quarterly 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 Reviewing**	**Director**	**Risk Owner (for Updates)**	**Initial Risk (LxI)**	**Current Risk (LxI)**	**Movement of current risk**	**Residual (Target) Risk (LxI)**	**Target date for completion of actions**	**Risk open or closed (If closed specify date)**	**Last reviewed**	
Medical Directorate Primary Care Commissioning	MDPCC12	N/A	13.08.18	~~There is a risk to access to primary care and to system resilience if general practice sustainability is not addressed.~~ **This risk has been reviewed and the description revised as follows:** **Issues related to GP Practice sustainability may limit access to primary care**	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 resilience 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)	**16 (4x4)**	↔	8 (2x4)	**Mar-19**	Open	**Dec-18**	
Nursing & Quality **Commissioning Directorate**	BNSSG QD 001 **11**	N/A	13.04.18	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 **Contractual systems in place to monitor and manage performance through APG and ICQPM's** **Hospital focussed improvement programmes** **Monthly breach meetings with providers** **Partnership engagement in STP-wide cancer system working** **Engagement with SWAG Cancer Alliance** **Monthly review of cancer performance indicators** **Ongoing monitoring of patient harm through existing CCG quality governance** **Oversight of funding for projects associated with Alliance national support fund**	Further mitigating actions require system wide focus on cancer pathway August 2018: CCG is part of harm review panels where issues are identified, assurance regarding performance is provided and monitored at Quality Sub Groups on a monthly basis. UHB have a revised remedial action plan in place for 62 day wait for cancer. There was an initial drop in performance following a fire at the Bristol Oncology Centre in May but this has now recovered and performance in June met the national target. The remedial action plan is in the process of being refreshed for Weston- but performance remains challenged. Breach meetings and escalation of risk of harm will continue as well as review of long waiting patients. The CCG are monitoring closely 2 week wait performance as this has been more challenged this quarter and again any patients where harm is identified will be escalated. New pathways are now in place and further introduction of national timed pathways are expected in quarter 3 for lung and colorectal as described.	none identified currently; monitoring of position continuing	Quality Committee **Commissioning Leadership Team / Commissioning Executive & STP Steering Group (ACC)**	Anne Morris **Lisa Manson**	Cecily Cook **Gemma Artz**	20 (4x5)	**15 (3x5)**	↔	10 (2x5)	**Mar-19**	Open	**Dec-18**	
						October 2018: Ongoing monitoring of performance. All Trusts continuing to review for harm and report to quality sub group. Weston asked to review harm for Breast 2 week waits. **November 18: Ongoing monitoring of mitigations** **December 18: Ongoing monitoring of mitigations** **Reviewed at monthly STP Cancer steering group which also feeds into the acute care collaboration**											
Nursing & Quality	BNSSG QD 002	N/A	13.04.18	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	August 2018: MRSA Blood stream Infections (BSI) - A new PIR document is being formulated to ensure input into the investigation from all providers both pre and post diagnosis of MRSA BSI to enable a whole system approach. Clostridium difficile Infection (CDI) - BNSSG CCG are implementing a single system for the management process for CDI across BNSSG following the CCG merger. E.Coli Infection - Implementation of a generic catheter passport is on track to be implemented by Q3. Data is being collected for all other Gram negative bacteraemias and the HCAI group will be including MSSA BSI and Wound Infections going forward. **October 2018** **MRSA: Patient information leaflets for IVDU being updated. Application made by BCC on behalf of partners to design council to assist with reducing MRSA. Planning for evaluation of clinnell wipes underway.**	none identified currently; monitoring of position continuing	Quality Committee	Anne Morris	Cecily Cook	20 (4x5)	**15 (3x5)**	↔	5 (1x5)	**Mar-19**	Open	**Dec-18**	

						E.coli - Printing of catheter passport in progress. HCAI group considering next work stream to maintain focus on reduction of cases November 2018 - Application for funding from Design Council to support reducing MRSA cases has been approved to assist further in investigating these cases. A system wide action plan will be developed and monitored as part of the work. Ecoli - The CCG is in the process of obtaining RCA's for community acquired cases and will conduct a detailed review to establish themes and inform further workstreams.												
Medical Directorate - Clinical Effectiveness	M01	PO3	08.08.18	**This risk has been reviewed and the description revised as follows:** As a result of NCSO & CAT M **drugs** - 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 review of position** **Ongoing discussion with NHSE**	Monthly monitoring accounts for additional costs of £50k (April) £200k (May) & £220k (June), £455k (July)	Often there are no alternatives available.	Quality Committee/Commissioning Executive and SFC	Peter Brindle	Debbie Campbell	20 (5x4)	**20 (5x4)**	↔	**TBC**	**Mar-19**	Open	**Dec-18**	
Medical Directorate - Clinical Effectiveness	MO2	PO3	08.08.18	~~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.~~ **This risk has been reviewed and is now incorporated into the risk MO1. This risk will be removed from the register once reviewed by the Governing Body**	Nationally implemented so with little control, will seek options for prescribing alternatives wherever possible.		Often there are no alternatives available.	as above	Peter Brindle	Debbie Campbell	20 (5x4)	**20 (5x4)**	↔	**TBC**	**Mar-19**	Open	**Dec-18**	
Commissioning Directorate	1	PO1	10.08.18	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 organisational 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 flexible 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 Commissioning directorate away day took place in Oct-18: -The vison and values collected have been collated and will feed into the wider organisational values. -Individual team objectives were created and have been collated centrally. -Gained an understanding of the different areas of work within the directorate. -Training and development needs confirmed with agreed next steps. **Risk score has been reviewed and reduced and recommended that risk is removed from Corporate Risk Register**	**This risk is detailed on the GBAF at PO1**	Commissioning Leadership Team / Commissioning Executive	Lisa Manson	Emma Moody	20 (5x4)	**3x4=12**	↓	TBC	**Mar-19**	Open	**Dec-18**	
Commissioning Directorate	2	PO2	10.08.18	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	**This risk is detailed on the GBAF at P02**	Commissioning Leadership Team / Commissioning Executive	Lisa Manson	Sarah Swift	25 (5x5)	**20 (4x5)**	↔	TBC	**Mar-19**	Open	**Dec-18**	
Commissioning Directorate	3	PO3	10.08.18	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 subsequently the CCGs credibility.	Engagement with providers through the control centre process to identify and implement system savings.	To be reviewed at CLT monthly	**This risk is linked to the risk PO3 on the GBAF which contains more detail on the management of financial recovery**	Commissioning Leadership Team / Commissioning Executive	Lisa Manson	Claire Thompson	25 (5x5)	**20 (4x5)**	↔	TBC	**Mar-19**	Open	**Dec-18**	
Commissioning Directorate	4	PO4	10.08.18	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	**This risk is linked to the risk PO4 on the GBAF which contains more detail on the working in partnership**	Commissioning Leadership Team / Commissioning Executive	Lisa Manson	Claire Thompson	20 (5x4)	**16 (4x4)**	↔	TBC	**Mar-19**	Open	**Dec-18**	

Commissioning Directorate	5	PO5	10.08.18	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	**This risk is linked to the risk PO5 on the GBAF which contains more detail on A&E recovery Visibility of system wide workforce information across primary care and secondary care reports to Governing Body**	Commissioning Leadership Team / Commissioning Executive	Lisa Manson	Julie Kell	20 (5x4)	**16 (4x4)**	↔	TBC	**Mar-19**	Open	**Dec-18**	
Commissioning Directorate	7	PO7	10.08.18	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.	**Effective contract management processes with the current provider. Joint working with BSW on contract requirements Joint Planning and delivery of the Estates Project and CCG leading consultation 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 CCG investment in Mental Health Investment Standard CCG commenced 19/20 contract negotiations on behalf of BNSSG and BSW Support provided to AWP for winter pressures**	To be reviewed at CLT monthly	**This risk is linked to the risk PO7 on the GBAF which contains more detail on the Mental Health services Define the lead indicators including patient reported measures and reports from primary care localities. Development of MH data set focussing on the IAF indicators underway, more work required to identify trends in reporting.**	Commissioning Leadership Team / Commissioning Executive	Lisa Manson	Emma Moody	20 (4x5)	**20 (4x5)**	↔	TBC	**Mar-19**	Open	Oct-18	
					Mental health key plank of the Locality Transformation Schemes Commissioning Executive has just approved full extension of mental health contracts for the Bristol Area. Appointment of new Director of Nursing and Quality and Chief Operating Officer in AWP.													
Finance Directorate	F03	PO3	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 **M7 acute activity showed significant increase and if repeated in M8 will present a significant risk to achieving the financial position. Additional mitigating actions have been taken in respect of urgent care pressures to improve system flow and to formalise referral management of elective activity with AQP providers.**	CCG is developing the integration of performance analysis and management **This risk is linked to the risk PO3 on the GBAF which contains more detail on the management of financial recovery**	**Strategic Finance Committee**	Sarah Truelove	Rob Moors	12 (4x3)	**4 X 4 = 16**	↑	1 x 3= 3	**Mar-19**	Open	**Dec-18**	
Area Directorate	NS08	PO8	05.10.18	There is a risk that the JDI work that come out of the Healthy Weston work is not incorporated in to the wider PCBC process, resulting in a lack of coordination making them less effective.	Joint planning with Healthy Weston Programme Director to ensure single process for codesign ideas. **Work is being developed on the frailty unit and Hood and Woolf are fully involved and engaged.**	**Hood & Woolf are involved in writing the Case for Change. Colin Bradbury is feeding in to the PCBC to ensure the messaging around JDI's are getting through and are put in to the public domain. Colin Bradbury is now the Executive Team lead for the Healthy Weston programme. Risk score has been reviewed and reduced and recommended that risk is removed from Corporate Risk Register**	**none identified currently; monitoring of position continuing**	Comm Exec	Colin Bradbury	Kirstie Corns	16 (4x4)	**2x2=4**	↓	3x2=6	Nov-18	Open	**Dec-18**	
Area Directorate	NS09	PO8	05.10.18	There is a risk that the HOSP do not feel engaged in the STP work and the development of the Integrated Care System, resulting in withdrawal of support.	The Area Director for North Somerset and the Director for People and Communities, North Somerset Council to provide joint STP updates to the HOSC. An additional seminar is to take place on 17.10.18.	**Julia Ross and Colin Bradbury had an additional meeting with the HOSC on Wednesday 17.10.18. There is an agreement with the Director of Adult Social Care that there will be a standing item on the agenda for an STP update and ICS at HOSC. Risk score has been reviewed and reduced and recommended that risk is removed from Corporate Risk Register**	**none identified currently; monitoring of position continuing**	Comm Exec	Colin Bradbury	Mary Adams	16 (4x4)	**3x3=9**	↓	3x2=6	Nov-18	Open	**Dec-18**	

Commissioning Directorate	9	n/a	20.11.18	**Capacity issues regarding the IFR Panel may result in delayed decision making with subsequent impact on patients**	**Requirements for Public Health support have been escalated and discussions are underway to secure this An Ethical Framework to support decision making is underdevelopment and will be approved by the Governing Body. This will support the governance structure for the panel There is a risk that support for evidence reviews may not be able to address this demand and this will be managed on a case by case basis and external Public Health support will be secured when required**	**reviewed at CLT monthly Risk score has been reviewed and reduced and recommended that risk is removed from Corporate Risk Register**	**The recruitment of further GP representation and a patient representative will be considered when the Ethical Framework for Decision Making is implemented further work is required to identify external support as and when required**	**Comm Exec**	**Lisa Manson**	**Niall Mitchell**	4 X 4 = 16	**4x3=12**	↓	2x3=6	Feb-19	open	**Dec-18**	
Nursing & Quality	BNSSG QD 021	N/A	6.12.18	**Patients are at risk of harm from call incident stacking at SWASFT causing a delay to ambulance response times**	**Discussed at monthly quality sub group. Daily system escalation calls Handover SOP in place with acute Trusts NHS 111 Clinical validation of Category 3 calls**	**SWASFT is a member of UCOB and participating in developing non conveyance projects QIA of all projects to include assessment on urgent and emergency care response Single item QSG held with NHSE. CSU developing system escalation triggers for call stacking Task and finish group to be set up to develop clinical validation of NHS 111 Category 2 calls in escalation**	**none identified currently; monitoring of position continuing**	**Quality Committee**	**Anne Morris**	**Cecily Cook**	**4x4**	**4x4 = 16**	↔	**TBC**	**Feb-19**	**Open**	**Dec-18**	
Commissioning Directorate	**12**	**N/A**	**19.12.18**	**Infectious disease outbreak including high consequence infectious diseases. (VHF Ebola / SARS / MERS)**	**Robust Outbreak Plans / Business Continuity Plans in place across health system. Outbreak planning is part of winter plans and surge; training and exercising for Local Resilience Forum and all NHS Organisations CCG Governing Body receives report on Emergency Preparedness, Response and Resilience preparedness annually.**	**To be reviewed at EPRR oversight delivery group**	**PHE Communicable Disease Incident & Outbreak Response Framework Draft LHRP Communicable Disease Incident & Outbreak Operational Response Plan waiting sign off Personal Protective Equipment Training & Exercising**	**EPRR Oversight Delivery Group**	**Lisa Manson**	**Janette Midda / John Wintle**	**5x3=15**	**5x3=15**	↔	**TBC**	**Mar-19**	**OPEN**	**NO**	**20/12/2018**
Commissioning Directorate	**13**	**N/A**	**19.12.18**	**Lack of coordinated response and special measures in the event of a mass casualty incident due to lack of operational plans and training. This increases the likelihood of substandard care and impacts on the health system.**	**Currently in Place: • LHRP Mass Casualty Plans including Emergency Treatment Centre (ETC) Standard Operating Procedure for P3 management and how to manage P1s and P2s. • Medical Treatment Team SOP signed off by LHRP. • Plans to be tested in regional mass casualty exercise. • Joint training package. • NHSE South Mass Casualty Framework. • LHRP Mass Casualty Response Plan.**	**To be reviewed at EPRR oversight delivery group**	**NHS / SWAST Joint Training package LHRP Mass Casualty Response Concept of Operation Updated LHRP Mass Casualty Plan in light of lessons learnt in 2017 Medical Treatment Team training signed off and implemented**	**EPRR Oversight Delivery Group**	**Lisa Manson**	**Janette Midda / John Wintle**	**3x5=15**	**3x5=15**	↔	**TBC**	**Mar-19**	**OPEN**	**NO**	**20/12/2018**
Commissioning Directorate	**15**	**N/A**	**19.12.18**	**An ineffectual radiation monitoring unit causing loss of public confidence and ineffective monitoring. Would also cause further strain on NHS resources already stretched by the response**	**There are no controls in place currently. NHSE progressing nationally.**	**To be reviewed at EPRR oversight delivery group**	**National activity developing a plan template for a RMU function has not progressed since 2014. Awaiting publication of national guidance before final version of Local Resilience Framework can be completed and approved. Local capabilities have reduced as there are a small number of Radiation Protection Advisers in acutes trusts in Avon and Somerset.**	**EPRR Oversight Delivery Group**	**Lisa Manson**	**Janette Midda / John Wintle**	**3x5=15**	**3x5=15**	↔	**TBC**	**Mar-19**	**OPEN**	**NO**	**20/12/2018**
Commissioning Directorate	**18**	**N/A**	**20.12.18**	**National EU Exit (Brexit) • Supply of medicines and vaccines; • Supply of medical devices and clinical consumables; • Supply of non-clinical consumables, goods and services; • Workforce; • Reciprocal healthcare; • Research and clinical networks • Data sharing, processing and access.**	**EPPR colleagues progressing the National requirements for local SW EU Exit plans (Local and regional NHSE and NHSI teams in place)**	**To be reviewed at EPRR oversight delivery group**	**none identified currently; monitoring of position continuing**	**EPRR Oversight Delivery Group**	**Lisa Manson**	**Janette Midda / John Wintle**	**4x4=16**	**4x4=16**	↔	**TBC**	**Mar-19**	**OPEN**	**YES**	**20/12/2018**

NHS
Bristol, North Somerset and South Gloucestershire
Clinical Commissioning Group

BNSSG CCGs Governing Body Assurance Framework (Dec 2018)

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**	**3x4 =12**	**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**	**3x5=15**	**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**	**3x3=9**	**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: December 2018</td></tr>
<tr><td>Risk Rating (Likelihood x impact)
Initial: 5x4=20
Current: 3x4=12
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
• Leadership development programme in place for clinical leads and SMT
• Management Training in place for all line managers
• Access to NHS Leadership Academy range of courses in place
• Attracting and developing diversity group established
• CSU HR and OD contract agreed with re-shaped resource to include more training capability
Mitigating Actions: (what further actions are needed to reduce the risk and close any identified gaps)
• 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</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>
</table>

• **SMT work on resource mapping exercise to ensure coverage of priorities and clarity of leadership.**	
Current Performance: *(With these actions taken, how serious is the problem?)* **Staff survey response rate at 79.1% shows a high level of engagement.** **Morale feels improved although further work to do on resourcing to ensure balance can be achieved with staff having stretching but achievable roles.**	**Additional Comments:**

Objective: Develop a Solution for Weston Hospital within BNSSG	**Director Lead: Colin Bradbury / 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: November 2018**
Risk Rating *(Likelihood x Impact)* Initial:5x5=25 Current:3x5=15 Appetite: 2x5=10	**Rationale for current score:** the case for change is published with system support. Healthy Weston Steering Group has established clear framework to enable options to be developed with strong clinical leadership and ownership. Programme plan in place to support consultation early in 2019.
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 and communications and engagement • Programme governance embedded • Case for change published **Mitigating Actions:** *(what further actions are needed to reduce the risk and close any identified gaps)* • Further work being progressed to support workforce modelling and impact on SWASFT	**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 **Gaps in Assurance:**
Current Performance: • Case for change and evaluation criteria to be received by Governing Body October 2018 • Progress on track regarding options development	**Additional Comments:** 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: December 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 of monthly system financial position • 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 • Improve internal communications to share position and best practice • Further training from PMO and budget holder training • Internal audit of QIPP processes underway • 2019/20 planning well under way and now being shared in detail with wider system. • System agreement of priorities for 2019/20 plan: workforce, urgent care, financial recovery	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 • 91% delivery to month 7 and improving forecast outturn **Gaps in Assurance:** *(What additional assurances should we seek?)* • Activity query notice raised to NBT for significant increase in non-elective activity but audit yet to report. • Unusual increase in activity at UHBT from M6 onwards • AQP costs accelerating with little ability to control

Current Performance: *(With these actions taken, how serious is the problem?)* Risk assessed position is currently £9m against a £37m plan (as at month 7).	**Additional Comments:**

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: December 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 • National planning guidance likely to mandate use of a blended tariff for urgent care • System wide planning workshop delivered consensus to key issues to be addressed in the plan • **System wide plan to deliver the plan agreed with milestones and ownership of the various elements** • **Principles agreed by Sponsoring Board and further discussions on review of system governance started** • **UEC planning event held** **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	**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

• Aspiring ICS support is giving capacity to developing plans and governance processes • 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. • 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 • **Work on revised governance for the system to include: planning, performance management and risk management** •	
Current Performance: *(With these actions taken, how serious is the problem?)* *Broad system agreement to needing to work together to develop a plan and the national guidance is supporting that discussion.*	**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: October 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.	**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 • Deep Dive Performance Report detailing position and action plans received at October Governing Body meeting **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~~

• Reporting through Commissioning Executive on sentinel performance 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 October 2018 • Urgent Care and Winter Plan Report received at Oct Governing Body meeting. Urgent care continues to be a major performance and quality challenge, and in common with other communities nationally the CCG has struggled to achieve and maintain the 4 hour standard.	**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: December 2018</td></tr>
<tr><td>Risk Rating (Likelihood x impact)
Initial:4 x 4=16
Current:3 x 3= 9
Appetite: 3x3=9</td><td>Rationale for current score: Scope is now agreed and timescales for procurement in place therefore risk score has been reduced to reflect the impact of mitigations.</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="2">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
Due Diligence and Scope approved at Governing Body Oct 18
metrics to monitor and review the extant providers developed and to be reviewed at SFC
service specification development with arrangements to fully engage stakeholders in place
Mitigating Actions: (what further actions are needed to reduce the risk and close any identified gaps)</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>Gaps in Assurance:
none identified – assurances are kept under review</td></tr>
</table>

• 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: November 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 Local Performance and Contracting Executive (BNSSG) only.
Patient Safety actively managed by Quality Committee sub group
Strategic Finance Committee engaged and kept informed of control centre and SDOG activity with a Finance Information Group meeting led by BNSSG CCG
Mental Health ~~embedded in all~~ standalone STP work-stream
Shared Leadership Development ~~commenced in May 2018)~~
~~Quarterly~~ Reporting to Commissioning Exec
Mitigating Actions:
Joint working with BSW on contract requirements
Joint Planning and delivery of the Estates Project with CCG leading consultation
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~~
CCG Investment in Mental Health Standard</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~~
Development of Mental Health data set focussing on IAF indicators underway, further work is required to identify trends in reporting</td></tr>
</table>

• CCG commenced 2019/20 contract negotiations on behalf of BSW • Support provided to AWP for winter pressures • Mental health ley plank of Locality Transformation Schemes • Appointment of new Director Nursing and Quality and Chief Operating Officer in AWP • Implementation of CCG MH MDT Governance Meeting to enable effective internal communication of Mental Health issues • Mental Health Performance Group (MHWSOG) instigated to review performance measures	
Current Performance: AWP continues to face significant financial pressures. The CCG remains committed to supporting AWP to deliver changes and achieve financial balance	Additional Comments the CCG will need to work closely with BSW to understand their contracting position. Currently Swindon is not party to the multi-lateral contract and BANES and Wiltshire are reviewing options. Further contractual fragmentation could impact on the provider.

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: December 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 (LTS) plan and agreed transfer of funds based on achievement of key milestones • IA specification and sign off via PCOG and contract monitoring in place • Integrated working ~~template~~ priorities ~~and~~ signed off via Integrated care steering group • Phase 3 LTS collaborative faculty and delivery plan established to ensure transparent and effective improvement of methodology and delivery across localities reporting to Integrated Care Steering Group • CCG locality development programme board established • Progress monitored against NHSE Primary Network Maturity matrix and reported • **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 • PPI plan to link to STP • Enactment of support via the Primary Care Networks programme	**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:** • Programme reporting established

Current Performance: *(With these actions taken, how serious is the problem?)*	**Additional Comments:**