Castle Point and Rochford Clinical Commissioning Group

Southend Clinical Commissioning Group

Appendix 1

Board Assurance Framework and Corporate Risk Register

December 2018

2018/19

Red (15-25)	**Extreme risk**
Amber (8–12)	**High risk**
Yellow (4–6)	**Moderate risk**
Green (1-3)	**low risk**

Board Assurance Framework December 2018/19

Strategic Objective 2018/19	Executive Lead	Link to Risk Register		Risks Identified	Date		Risk Level (initial)	Rating of Risk to Objective (Current)	Risk Level (Target)	Identified Control			Control Gaps	Assurance		Assurance Gaps	Actions to Address gaps (controls and assurance)		
What the organisation aims to deliver (outcome required	Board level lead responsible for achievement of the objective	All Risks	No	What could prevent us from meeting the objective?	Date added	Date reviewed	Low/Moderate/ High/ Extreme	Low/Moderate/ High/ Extreme	Low/Moderate/ High/ Extreme	Primary Controls (closest to area of risk)	Secondary Controls (detective)	Tertiary Controls (includes external audits, internal audits, clinical audit, Royal College and other reviews)	Are the identified actions achieved?	Report of GB where controls and assurance around risk is presented	Governing Body Committee where actions are monitored and assurance is provided to GB	Where we are not gaining effective evidence?	Further evidence/ actions to address control and assurance gaps	Responsible Officer (to deliver specific action)	Timescale for achievement
Objective 1: Developing models of care to support people out of hospital																			
Executive Lead: tbc (Simon Williams and Jacquie Lansley)																			
Governing Body Committee: Quality Finance and Performance																			
	Director of Primary Care and Operations		AF 1a	**DEMAND MANAGEMENT** IF demand exceeds capacity in a way that cannot be managed by the CCGs THEN there is a risk to quality or services and patient experience and a risk that future contracting between the CCGs and SUHFT will move back to PbR increasing the financial challenge of the organisation RESULTING IN escalation to NHSE Regional Team and potential qualification of statutory accounts and loss of autonomy.	01.10.18	10.01.19	**16 (Extreme)**	**16 (Extreme)**	**12 (High)**	1. CCG Strategic Plan 2. QIPP Plan with measurable outcome targets 3. Indicators of success/ failure in demand management and action plans as needed. 4.CQUINS monitoring. 5.Clinically led work streams. 6.Financial Recovery plan developed. 7. PMO established and Finance Recovery Committee established, incorporating functions of Turnaround. 8. Executive Management Team now recruited to and now has revised focus on business cases and QIPP. 9. A&E Delivery Board providing system wide coordination of recovery and daily delivery 10. Urgent Care Improvement Plan Seasonal Surge and Escalation plan.	1. Quality Finance Performance Committee monitoring of QIPP and performance. 2. FRG now in place to address economy wide pressures. Governing Body minutes. 3. External CCG Assurance Framework and meetings with NHSE. 4. Monitoring of Financial Recovery Plan through QFP Committee and new CMT focus. Monitoring impact of Primary Care Quality Scheme through Primary Care Committee. 5. STP/local A&E Delivery Board 6.. Performance Reports to GB (bimonthly). 7. Monthly Performance reports to QFF (minutes to GB) 8. Daily Operational oversight within the hospital and wider system/OPEL framework including executive escalation in place. 9. Standard operating procedures to manage ambulance handovers delays. 10. Joint QIPP schemes with SUHFT, EPUT and CCG Priority action plan focused on workforce/acute bed reconfiguration/new ways of working/prioritisation of EPUT community services to support demand reduction/care home and general practice engagement for increasing out of hospital care.	1. Mazars QIPP Audits - Limited Assurance	See Audit recommendations Fragility of the domiciliary care and care provider market. Significant Nursing and medical work staff vacancies with challenges in on going recruitment. Increased demands on the hospital is exceeding speciality capacity remains fragile.	Escalation from QFP	Quality, Finance and Performance		Delivery of the QIPP demand management schemes from April 2018 onwards. Deliver recovery and sustainable delivery of the urgent care improvement plan. Ongoing. Need to deliver Winter Plan 2018/19 (first draft July 2018)	EG	Mar-19
	Director of Strategy and Planning		AF 1b	**INNOVATION** IF the CCGs fail to transform services to meet the changing health needs of the populations THEN services may not meet the needs of patients. RESULTING IN failure to reduce health inequalities within our geographical areas	22.12.16	10.01.19	**12 (High)**	**12 (High)**	**3 (Low)**	1. QIPP/Commissioning Plan/Urgent Care/Strategic Plan all require innovation to change to system. Examples of innovation in Pharmacy, Single Front Door, Advice and Guidance. 2. Delivery against planning guidance and the Five Year Forward View. 3. New Organisational Development Strategy approved. 4. Financial Recovery Group in place.	1. Governing Body minutes. 2. CCG plans. 3. Organisational Development implementation plan. 4. Financial Recovery Group meetings and monitoring of QIPP Plan via Quality, Finance and Committee				Quality, Finance and Performance			CMT	
Objective 2: Delivering local and national priorities, ensuring earned autonomy from regulators																			
Executive Lead: (Mark Barker/Charlotte Dillaway)																			
Governing Body Committee: Quality, Finance and Performance																			
	Director of Strategy and Planning		AF 2a	**PRIORITIES & OBJECTIVES** IF the CCGs fail to deliver on agreed health priorities and objectives. THEN the CCGs will not complete transformation programmes or deliver on KPIs and statutory targets RESULTING IN poor quality service provision and worsening health outcomes	01.10.18	10.01.19	**16 (Extreme)**	**16 (Extreme)**	**6 Moderate**	1. CCG Strategic Plan 2. NHS England performance monitoring 3. Contract meetings 4. Quality and Performance Committee Monitoring. 5. Refreshed Strategic Plan. 6. Financial Recovery Plan. 7. Finance Recovery Committee established.	1: Performance reports to Governing Body. 2. Quality, Finance and Performance Committee minutes. 3. External CCG Assurance Framework. 4. Monitoring of Financial Recovery Plan through QFP Committee and SMT focus on delivery evidenced through minutes and papers.				Quality, Finance and Performance			MA	
	Chief Finance Officer		AF 2b	**FINANCIAL PRESSURES** IF the CCGs do not exercise strong financial stewardship and governance THEN the CCGs may not achieve their statutory breakeven duty. RESULTING IN Regulatory intervention, lack of timely and robust decision making, qualified external audit opinion, possible merger scenarios, increased instability within both organisations	01.10.18	10.01.19	**20 (Extreme)**	**15 (Extreme)**	**6 Moderate**	1. Financial recovery Plans in place with close scrutiny from the Financial Recovery Group (FRG) 2. QFP receive monthly finance reports against financial plan 3. CMT and Executive review progress on Improvement Plan, emerging financial pressures and specific 4. PMO monitor QIPP schemes, reporting to QFP monthly 5. Monthly reports to NHSE 6. Monthly budget holders meeting, producing redial actions if necessary 7. Improvement Director appointed to ensure sustained improvement and maximum delivery of QIPP plan 8. System wide QIPP schemes in place 9. Increased PMO meetings and project leads	1. Both CCGs have submitted financial plans that forecast delivery of the NHSE financial control target. 2. NHSE publish consolidation information for Midlands and East CCGs. 3. Finance team populate monthly ISFE returns. 4. Reports to CFO monthly meetings. 5. Joint CFO and AO roles across SE Essex CCGs. 6. Monthly Finance reports to GB 7. Regular reports to GB on STP plans (bi monthly). 8. Contract Management reports to QFP. 9. QFP minutes go to the bi-monthly GB meeting. 10. Joint development working across SEE CCGs and (monthly). 11. FRG Minutes to GB (bi monthly)	Internal and External Audit of financial systems and processes		Finance Report	Quality, Finance and Performance, Governing Body			LB	
	Director of Strategy and Planning		AF 2c	**QIPP DELIVERY** IF the CCG does not deliver its QIPP and evidence its ability to report accurately and precisely whilst acting on risk mitigation. THEN we will not achieve financial balance and there is a risk to the continuation of the block contract arrangement with SUHFT. RESULTING IN qualified external audit opinion and regulatory action, inadequate delivery of QIPP programme, pressure to find additional QIPP.	01.10.18	10.01.19	**20 (Extreme)**	**16 (Extreme)**	**6 Moderate**	1. Development and monitoring of Financial Recovery Plan. 2. QIPP Plan. 3. Financial Recovery Group established. 4. PMO established and joint QIPP schemes in place across SEE/STP. 5. Project Initiation Documents showing benefits analysis in place. 6. Management of project deadlines by FRG. 7. Scrutiny and assurance on QIPP programmes to QFP. 8. Progress updates to CEC.	1. External CCG Assurance Framework. 2. Monitoring of Financial Recovery Plan through GB. 3. Updates to Governing Body via Performance Reports 4. Monthly benefits analysis on programmes to ensure progress or stop non beneficial projects	1. Mazars QIPP audit - Limited	Easy schemes explored, need for sophisticated ways to deliver transformation. Additional QIPP may destabilise other services within the system if a programmatic approach is not taken.	FRG update Report	Quality, Finance and Performance, Finance Recovery Group		1. Formal benefits analysis of schemes needs to be apparent to evidence schemes will realise overall goals	EG	1. Feb 19
	Director of Strategy and Planning		AF 2d	**Statutory Targets.** IF the CCG fails to define appropriately plan for and subsequently deliver its statutory targets. THEN the CCG will fail to deliver its outcomes on plans and statutory responsibilities. RESULTING IN regulatory action and poor outcomes for patients.	01.10.18	10.01.19	**16 (Extreme)**	**16 (Extreme)**	**6 Moderate**	1. Success Regime Leadership Group 2. Monthly Performance Report in place for QFP and GB. 4. Weekly updates to CMT on areas of concern. 5. Joint reporting with Southend CCG. 6. Bi-monthly Joint Clinical Executive meetings. 7. Success Regime Meetings.	1. Monthly Cross System Delivery Board with providers ensuring alignment & understanding of bigger picture. 2. Governing Body reporting to both CCGs. 3. Bi weekly updates to Staff at staff briefing.			Integrated Performance Report	QFP		1. Clarity statutory targets and performance against them. 2. Increased collaboration across STP footprint. 3. Development possible joint approach to some targets across STP footprint.	MA	1. Jan 19 2. Mar 19 3. Apr 19
Objective 3: Strong voice in system wide plans																			
Executive Lead: (Charlotte Dillaway)																			
Governing Body Sub-Committee: Quality, Finance and Performance																			
	Directors of Partnerships		AF 3a	**SYSTEM WIDE WORKING** IF the system fails to work together in partnership THEN it makes it difficult to mutually agree a joint way forward for the future of healthcare services across the system. RESULTING IN possible fragmented services, delays in agreeing future service models, increasingly poorer services and inefficiencies	01.10.18	10.01.19	**15 (Extreme)**	**15 (Extreme)**	**4 (Moderate)**	1. STP with membership from all CCGs, JSNA and HWB Strategy and Board, development of service specifications and a System delivery at its heart which require collaborative approach, 2. Joint CQUIN development 3. Social Care/Public Health representation on CCG Governing Body. 4. Integrated planning processes. STP in place. 5. Section 75 present.	1. Social Care/Public Health updates to CCG Governing Body. 2. Reports to Health and Wellbeing Board. 3. Better Care Fund Plan sign off by HWB and pooled budget arrangements. 4. Minutes of STP to GB.				Governing Body			CD	

	Director of Strategy and Planning		AF 3b	**New Risk: BREXIT - DEAL OR NO DEAL** IF the UK executes a managed or unmanaged departure from the EU THEN there is increased uncertainty about the availability of a quality workforce. In addition, there will be increased uncertainty regarding the procurement of critical supplies including medicines and equipment RESULTING IN an impact on service delivery, unplanned increased cost for NHS, Social Care nationally, system wide and locally.	28.12.18	10.01.19	**16 (Extreme)**	**16 (Extreme)**	**10 (High)**	1. CCG contributes to discussion at a strategic level via STP membership. 2. CCG to explore scenario planning for deal or no deal situation.			Direction of travel not yet clear. Letter from SOS (07 Dec) outlining contingency planning re pharmacy, vaccines, EU Settlement Scheme and business continuity (letter filed).	AO Update Report	QFP, CEC		1. Start scenario planning and exploring directions of future travel.	CD	1. Dec 19
	Director of Primary Care and Operations		AF 3c	**New Risk: Major Disease Outbreak** IF there is a major outbreak of disease (e.g. pandemic flu) or a major incident occurs; THEN this could result in a mass casualty situation leading to local health care providers being significantly challenged in terms of their capacity to respond to the demands posed by the incident, RESULTING IN other multi-agency organisations in the region/nationally having to provide mutual aid and potential delays in treatment.	28.12.18	10.01.19	**15 (Extreme)**	**15 (Extreme)**	**10 (High)**	1. Emergency Planning Team in place hosted by Mid Essex CCG and working across the STP. 2. Flu Pandemic Plan, LHRP Mass Casualty Plan. 3. EPRR and BCM Policies. 4. Mandatory EPRR /BCM training. 5. Incident Co-ordination centre training with Loggists and on call staff. 6. CCG staff have attended Loggist training. 7. Gold command training for on-call staff. 8. NHSE core EPRR Standards assurance process. 9. NHSE Monitoring of terrorism threat level. 10. Memorandum of Understanding between providers and CCGs re provision of mutual aid / support.				EPRR updates provided to QFP and Audit Committee. These include details of CCG exercises against its own EPRR/BCM plans.	QFP/Audit Committee			JC	
	Director of Partnerships - Southend		AF 3d	**New Risk: Pan Essex 24/7 MH Crisis** IF additional measures in relation to the provision of Pan Essex 24/7 MH crisis response pathway redesign plan to meet the requirements of the Policing and Crime Act 2017 are not implemented, THEN this could result in the CCGs failing to meet their responsibilities under the Act, RESULTING IN possible legal challenge, reputational risk, increased demand on A&E Departments, risk to relevant patients, non-delivery of core crisis care concordat requirements and financial risks associated with an increased need for S136 suites.	28.12.18	10.01.19	**16 (Extreme)**	**12 (High)**	**4 (Moderate)**	1. Monthly system-wide conference calls in place.							1. Multi-agency MH Summit held to review breaches, understand opportunities for improved processes, foster relationship building - follow up Summit to be organised. 2. Develop plan for crisis on an STP footprint linked to psychiatric liaison transformation monies.	HJ/MT HJ/MT	Completed June 2018

Corporate Risk Register December 2018/19

Strategic Objective 2018/19	Executive Lead	Link to Risk Register	Risks Identified		Date		Risk Rating (Initial)	Rating of Risk to Objective (Current)	Risk Rating (Target)	Identified Control			Control Gaps	Assurance		Assurance Gaps	Actions to Address gaps (controls and assurance)		
What the organisation aims to deliver (outcome required	Board level lead responsible for achievement of the objective	All Risks	No	What could prevent us from meeting the objective?	Date added	Date reviewed	Low/Moderate/ High/ Extreme	Low/Moderate/ High/ Extreme	Low/Moderate / High/ Extreme	Primary Controls (closest to area of risk)	Secondary Controls (detective)	Tertiary Controls (includes external audits, internal audits, clinical audit, Royal College and other reviews)	Are the identified actions achieved?	Report of Board where controls and assurance around risk is presented	Board Committee where actions are monitored and assurance is provided to Board	Where we are not gaining effective evidence?	Further evidence/ actions to address control and assurance gaps	Responsible Officer (to deliver specific action)	Timescale for achievement
Objective 1: Developing models of care to support people out of hospital																			
Executive Lead: Jacqui Lansley/Simon Williams																			
Governing Body Sub-Committee: Joint Clinical Executive Committee																			
None																			
Objective 2: Delivering local and national priorities, ensuring earned autonomy from regulators																			
Executive Lead: Mark Barker/Charlotte Dillaway																			
Board Committee: Quality, Finance and Performance																			
	Director of Strategy and Planning		CRR 2a	**New Risk: Staff Vacancies** IF the CCGs structure is unaffordable/not fit for purpose. THEN vacancies will need to be held and existing staff morale will be impacted upon as work loads increase. RESULTING IN failure to deliver our Constitutional standards increased staff sickness and increased staff turnover, failure to deliver core services.	28.12.18	10.01.19	**9 (High)**	**16 (Extreme)**	**3 (Low)**	1. Regular discussion at CMT around the management of vacancies. 2. Staff survey presented at CMT and GB and action plan agreed. 3. Regular updates of performance against constitutional standards to QFP and GB. 4. Reduced reliance on interim staff where duties can be fulfilled by recruitment. 5. Prioritisation model approved at CMT.	1. Regular discussions with key stakeholders (Trust, LA) on CCG constitutional standards to ensure progress and compliance.	Governance Audit	NHSE asking for a further 20% overhead saving	Governance Report	QFP, AC		1. Risk assessing roles and prioritising for recruitment 2. Prioritisation exercise undertaken by ADs and presented to CMT for approval in relation to all projects held on the PMO's project whiteboard (90 in total). 3. Review of staff structure to be undertaken as not fit for purpose.	CMT ADs CG	
	Director of Strategy and Planning		CRR 2b	**New Risk: Staff - Succession Planning** IF the CCGs fail to undertake appropriate succession planning, THEN the organisations structures will not be fit for purpose, RESULTING IN failure to deliver against our objectives, lack of progression for staff, staff leaving the organisation, loss of knowledge and organisational memory.	28.12.18	10.01.19	**9 (High)**	**9 (High)**	**3 (Low)**	1. OD strategy agreed and action plan in place 2. Talent map complete 3. Staff training programme agreed and progress 4. New structures in place following consultation and implementation	1. Regular reporting to QFP via Governance Report	Governance Audit	New structure means that talent mapping exercise may need to be refreshed	Governance Report	QFP		1. Talent map to be refreshed in light of new structures to include new members of staff. 2. Succession Plan developed for CMT review.	MA MA	
	Director of Primary Care and Operations		CRR 2c	**Workforce - EEAST** IF there is a risk to service delivery and meeting national standards due to staffing shortages and growing demand for service across Essex. THEN there will be a shortage of Ambulance services across the patch and the service will be patchy. RESULTING IN increased waiting times for emergencies and a poorer service from EEAST.	07.11.13	10.01.19	**20 (Extreme)**	**16 (Extreme)**	**6 (Moderate)**	1. Transformation plan in place with clear CCG level trajectories. 2. Monthly EEAST Contract Review meetings. 3. Performance reports to QFP. 4. A&E Delivery Board 1/12. 5. Surge Escalation Plans in place. 6. Regional ECAT increasing staffing to improve hear and teat (9%). 7. Regional RAP in place approved by NHSE 8. RAP in place links to business Dev Plan for Trust. 9. Demand management Plan/QIPP schemes	1. Minutes of A&E Delivery Board go to Governing Body bi-monthly. 2. NHSE National Assurance Programme - performance monitoring. 3. 2017/18 Winter plan in place. 4. EEAST published revised strategy.		1. Staffing shortages. 2. Increasing CATI (R1) demand		Quality, Finance and Performance Committee		1. Recruitment drive through Essex media e.g. local radio and newspapers. 2. Focus on CAT1. 3. Service review (regional) in progress.	Joint Committee	
	Chief Finance Officer		CRR 2d	**New Risk Fraud** IF the organisations fail to have robust systems and processes for financial and non-financial transactions THEN the CCGs may be open to fraudulent activity RESULTING IN loss of earnings for the CCGs, increase in criminal activity within the CCGs	28.12.18	10.01.19	**16 (Extreme)**	**16 (Extreme)**	**6 (Moderate)**	1. SOs and SFIs being refreshed 2. Procurement training taken place 3. Sign off limits re-freshed ensuring expenditure sign off at appropriate seniority. 4. Budget review taken place 5. Adequate segregation of duties implemented to eliminate confusion of duties and crossover.	1. Report to QFP and GB on finance	Governance Audit, Financial Audit		Finance Report	QFP, GB		1. Completion of review of Sos and SFIs	LB	1. Feb 19
	Chief Finance Officer		CRR 2e	**Finance - savings and efficiencies** IF the CCGs cannot find the additional 20% efficiencies that are required THEN the organisations are in danger of not meeting their financial obligations and/ or control totals RESULTING IN increased financial pressures, increased focus on financial bottom line	28.12.18	10.01.19	**16 (Extreme)**	**16 (Extreme)**	**6 (Moderate)**	1. Financial recovery Plans in place with close scrutiny from the Financial Recovery Group (FRG) 2. QFP receive monthly finance reports against financial plan 3. PMO monitor QIPP schemes, reporting to QFP monthly 4. Monthly reports to NHSE 5. Monthly budget holders meeting, producing redial actions if necessary 6. Finance lead of proposals to find savings without de-stabilising the CCG. 7. Systems in place within the CCG for appropriate challenge and review of proposals via CMT, QFP, CEC and GB.	1. Financial reports to QFP, CEC and GB on proposals, with consequences, risks and mitigations.	Internal and External Audit of financial systems and processes	May need to re-think what we govern and/or see as "material" within the CCG to meet 20% savings.	Finance Report	QFP, CEC		1. Proposals required on 20% reduction without de-stabilising the organisations	LB	1. Feb 19
	Chief Nurse		CRR 2f	**Patient Safety/ Care- DoL** IF the CCG does not identify those patients who meet the criteria for implementation of Deprivation of Liberty Safeguards (DoLS). THEN people will receive inappropriate levels of restriction or restraint. RESULTING IN patient injury, possible legal action, possible hard to others in the same environment.	30.05.18	10.01.19	**15 (Extreme)**	**15 (Extreme)**	**6 (Moderate)**	1. Essex-wide approach led by Essex County Council. 2. Agreed application to Court of Protection for CHC funded patients who meet the criteria for DoLs and receiving domiciliary care underway. Prioritisation list made of those CHC funded patients that meet the criteria for DoLs.	1. Four people with Care funded by Southend CCG have had applications made to the Court of Protection for authorisation of their Deprivation of Liberty.		% of appropriate staff who have completed MCA and DoL training Development of a plan to identify the number of applications that appear appropriate to make to the Court of Protection and a plan to carry them out. % of appropriate staff who have capacity to undertake applications to the Court of Protection		Quality, Finance and Performance		1. Ensure full compliance with Mental Capacity Act training and Deprivation of Liberty Training by CCG staff who undertake care and needs assessments for those funded by the CCG so that it can be identified when someone's is being deprived of their Liberty. 2. Need process in place so that the CCGs have staff in place who can undertake the application process to the Court of Protection.	LS	
	Director of Primary care and Operations		CRR 2g	**Patient Care/ Safety - Ophthalmology** IF there are delays in outpatient appointments for Ophthalmology. THEN there is a risk of significant patient harm due to excessive waiting times. RESULTING IN unnecessary patient harm within Ophthalmology Service, a loss of confidence in local NHS services and increased risk of financial pressure to the Trust and JCT to see patients within reasonable timeframes.	08.12.17	10.01.19	**20 (Extreme)**	**10 (High)**	**10 (High)**	1.Detailed improvement plans (Recovery Plan monitored SUHFT 2. Access Board and Improvement plan monitored via Steering Group) discussions overseen by NHSE. 3. Sis monitored via the CCG SI Group and SUHFT CQRG. 4. Ophthalmology Summit held to gain support across Essex to improve the way services are delivered in and out of hospital (7 Sept). 5. Oversight and scrutiny of all SIs relating to Ophthalmology, are themed and information shared with other Essex CCGs whose population uses the HES. 6. Weekly PMO meetings to discuss status of QIPP delivery.	1. The Ophthalmology serious incidents are discussed at the Essex Quality Surveillance Group and information shared with commissioners and regulators.	Risk prioritisation audits completed at both Trusts.	New models of community based care not yet fully operational. Children's services operational from 04/12/17 Post operative cataract (Dec 17). Referral by ERS inc consultant advice and guidance (April 18) Primary care pathway (April18) Full implementation of pathway (Sept 18) .	Monthly reports to QFP minutes to GB. 3. Monthly CQRG minutes to GB (bi monthly). 4. Weekly PMO meetings - minutes to form PMO QIPP delivery update reports to CEC, QFP and GB. 5. CEC and QFP minutes to GB bi monthly.	Quality, Finance and Performance Committee		1. Incidents continue in Q3 2017, however not clear at this stage of investigation if related to backlog, monitoring continues via the CQRG, NHSE and NHSI 2. CCG Quality team conducted an audit of current service an action plan is being developed 3. CCG to meet with SUHFT to discuss improvement plan and immediate actions (29.11.17) 4. STP have responsibility for the this service but it is still a concern to the CCG as CCG still has accountability. Check this is on the STP risk register. 9/11/18. Progress with new service model is progressing to timetable for January full mobilisation - this is the long term solution to the problem of under capacity in the ophthalmology service leading to excessive waits. The number of SIs due to long waiting has now significantly reduced and numbers of overdue follow ups has fallen at MEHT and not risen at SUHFT relative to Mar 18. Likelihood of risk therefore revised.	Joint Committee	
	Director of Primary care and Operations		CRR 2h	**New Risk:** IF CCG on-call staff do not have the relevant experience and training, THEN they will be unable to effectively lead on and support NHS England and the system in an emergency situation. RESULTING IN a potential for delays in responding and possible loss of life/stress to those on-call.	28.12.18	10.01.19	**12 (High)**	**12 (High)**	**4 (Moderate)**	1. On-call training provided. 2. CCG Resilience Team lead provide advice and information on lessons learned from on-call incidents. 3. Major Incident training provided. 4. EPRR Team provide advice during working hours. 5. AD of Resilience holds On-call Forum. 6. CCGs' Incident Response Plan outlines strategic roles and action cards held in the incident room. 7. Castle Road accessible 24/7.		Emergency Planning audit undertaken. External test undertaken on CCGs' Lockdown Policy.	Recommendations from exercises held developed into action plans.					JC	
Objective 3: Strong voice in system wide plans																			
Executive Lead: Charlotte Dillaway																			
Board Committee: Quality, Finance and Performance																			
	Director of Strategy and Planning		CRR 3a	**Strategic and Operational Plans.** IF the CCG fails to define appropriately and subsequently deliver its strategic and operational plans. THEN the CCG may fail to deliver its outcomes on plans and statutory responsibilities. RESULTING IN regulatory action and poor outcomes for patients.	01.07.14	10.01.19	**16 (Extreme)**	**16 (Extreme)**	**3 (Low)**	1. Success Regime Leadership Group 2. CCG AO designated lead for Primary Care and Localities enabling alignment with local strategy. 3. Frailty and EoL Work stream/Board enabling alignment to local transformation programme. 4. Weekly updates to CMT on SR programme. 5. Joint Directorate meetings with Southend CCG. 6. Bi-monthly Joint Clinical Executive meetings. 7. Success Regime Meetings.	1. Monthly Cross System Delivery Board with providers ensuring alignment & understanding of bigger picture. 2. Governing Body review all draft and final Success Regime documents & business cases. 3. Monthly verbal report to GB meetings and seminars from AO. 4. Minutes of GB and Seminar meetings. 5. AO & Chairs meetings to discuss implications. 6. Success Regime a standing item on bi-monthly Governing Body meetings. 7. Weekly updates to CMT. 8. Bi weekly updates to Staff briefing.		System governance for the end stage strategic vision is not yet clear. Unclear on management cost requirement for joint working structures. Unclear on impact of local staff teams.	Integrated Performance Report, Update report on Operational Plan	QFP		1. Clarify the end stage strategic vision. 2. Development of pre consultation Business Case to be shared with GB. 3. Increased collaboration across STP footprint. 4. Development of joint governance structures across STP footprint. 5. AO and Lead STP directors in place.	CD	1. Jan 19 2. Jan 19 3. Mar 19 4. Apr 19 5. Apr 19

	Director of Strategy and Planning		CRR 3b	**QIPP Identification** IF the CCGs fails to identify adequate QIPP in relation to the block contract with MSB THEN the CCGs may find it difficult to extract additional QIPP at a later date from the contract RESULTING IN possible no-delivery of whole QIPP programme and difficulties in finding additional QIPP not related to hospital services.	28.10.16	10.01.19	**12 (High)**	**12 (High)**	**3 (Low)**	1. Project Initiation Documents showing benefits analysis in place. 2. Early discussions with Trusts taking place. 3. Early identification of QIPP projects to ensure highest possible chance of success. 4. Progress updates to QFP, CEC and GB.	1. Updates to Governing Body via Performance Reports 2. Monthly benefits analysis on programmes to ensure progress or stop non beneficial projects	Internal Audit on QIPP programmes	Additional QIPP may destabilise other services within the system if a programmatic approach is not taken.	FRG update report	QFP		1. Formal benefits analysis of schemes needs to be apparent to evidence schemes will realise overall goals 2. Early discussions with providers to take place to ensure QIPP schemes are agreed	EG	
0	Chief Nurse		CRR 3c	**Workforce - Primary Care.** IF due to lack of GP workforce within Primary Care there is a shortage of primary care expertise in the area. THEN this could lead to patient safety risks within practices, patients not receiving the services they need to stay well and lead a healthy lifestyle and GPs voluntarily terminating their contracts. RESULTING IN a negative impact on patient care, health and service, increased foot fall at A&E, increased stress and pressure within Primary Care.	02.05.17	10.01.19	**20 (Extreme)**	**20 (Extreme)**	**6 (Moderate)**	1. EU working Group (STP plus North Essex) monthly meetings. Community Education Provider network (CPR, Southend, Mid CCGs) monthly. 2. Primary Care Transformation & Development Group (STP) bi monthly CCG Chief Nurse Chairs group. 3. Local Essex wide workforce strategy in place. 4. EU GP Scheme. 5. Comms to public to raise awareness on effective use of GP time. 5. Dev of Mentoring programme and recruitment and retention campaign. 6. GP trainees due to quality in summer 2018 working with potential employers to facilitate an introduction between the two. 7. Comms to potential candidates to work within the area. 8. With regard to the international wave 3 bid for GPs has been successful and awaiting for a date for this to commence which will run parallel to the initial Pilot.	1. Monthly update to Clinical Executive Group (CEC) and NHSE. 2. CEC minutes to GB bimonthly. 3. EU GP monthly financial and data report to NHSE central team providing quarterly assurance reports to NHSE on the delivery of the workforce plan. 4. Workforce included within the Chief Nurse report which is presented to QFP monthly. 5. QFP minutes to GB (bi monthly). 6. Reports to Primary Care Transformation Development Group (bi monthly), Local Workforce Action Board (bi monthly)		Possible recruitment issues with regard to lack of suitable and willing candidates to move to Essex. Ageing workforce particularly nurses looking for new initiatives with regard to future recruitment mindful that funding has not yet been identified.	Escalated via QFP.	Joint CEC, Quality, Finance and Performance Committee		1. Time to Care, active signposting, appointment management, best use admin. 2. Up skilling practice nurses and existing roles. 3. Agreement at AO meeting March 2018 to form an STP training hub which will replace the mid and SE CEPN. 4. Training Hub workforce facilitator commencing with CCG on 19 April to implement training needs analysis and workforce initiatives across mid and SEE. 5. Awaiting outcome of procurement moderation meeting which will identify candidates for appointment (Procurement Committee April 2018) 6. Agreement for funding from NHSE to cover the HMRC payments for the candidates and to ensure recruitment of 50 GPs in totality.	CN	
	Chief Nurse		CRR 3d	**Workforce Shortages** IF there is a risk of insufficient capacity in the wider health system. THEN there will be an inability to deliver high quality care RESULTING IN poor care and care outcomes for patients	26.07.18	10.01.19	**16 (Extreme)**	**9 (High)**	**6 (Moderate)**	1. SUHFT and EPUT have recruitment and retention plans in place. 2. Essex wide primary care workforce development centre commissioned as pilot for two years. 3. Locality approach to integrating services across primary, community and social care being developed. 4. Dedicated GP service for are homes being commissioned to relieve pressure on GP practices, although currently not being able to engage a provider. 5. Care coordination in place. 6. Inclusion of KPIs for staffing and recruitment for SUHFT, EPUT workforce recruitment plans, Health Education England recruitment strategy. 7. Chief Nurse monitoring EPUT and SUHFT workforce recruitment plans through CQRGs.	1. Monthly EPUT and SUHFT CQRG meetings minutes to QFP (monthly) and GB (Bi monthly). 2. Monthly Quality Reports to QFP.		All recruitment plans impacted on national shortage of key healthcare professionals.		Quality, Finance and Performance Committee		1. Significant issues with medical and nursing workforce at SUHFT and EPUT still remain below trajectory (Jan 2018). 2. The STP Group Hospital model is addressing some of the significant workforce issues.	Joint Committee	
	Director of Primary Care and Operations		CRR 3e	**New Risk: Teletracking System - SUHFT** IF local IT networks are insufficient to support teletracking system. THEN additional pressure is placed on SUHFT staff to work round technical issues and impact on local NHS staff due to the amount of data being transferred within the available bandwidth resulting in STP wide IT issues (including primary care). RESULTING IN delays in transferring and discharging patients from SUHFT and impact on NHS staff time across the STP dealing with IT issues.	28.12.18	10.01.19	**16 (Extreme)**	**9 (High)**	**6 (Moderate)**	1. SUHFT has business continuity in place to manage if tele tracking system fails 2. Teletracking Operations Lead will be working on SUHFT site in early January to help embed working practice with clinical staff (minimise paper workarounds)					Quality, Finance and Performance Committee			JC/PK	
	Director of Strategy and Planning		3f	**New Risk: Information Governance** IF the CCG does not have comprehensive Information Governance (IG) and information technology (IT) security procedures in place, THEN there is a risk that there will be breaches of confidentiality or failure to disclose information held in response to Freedom of Information requests. RESULTING IN loss of public confidence and possible referral of the CCG to the Information Commissioner's Office.	28.12.18	10.01.19	**15 (Extreme)**	**12 (High)**	**6 (Moderate)**	1. IG training mandatory for all staff. 2. FOI process in place including responses by Senior Information Risk Owner (SIRO) 3. Data Flow Mapping undertaken. 4. Information assets registers in place. 5. Restricted access to IT systems and folders. 6. Essex-wide IG Team in place. 7. Essex-wide IG policies and procedures. 8. Appointment of trained SIRO - Director of Strategy and Planning. 9. Appointment of trained Caldicott Guardian (Chief Nurse).		1. Internal audit of compliance with IG toolkit (Level 2 compliance with IG Toolkit).		EPRR Updates provided to QFP and Audit Committee and escalated to GB through Integrated Performance Report.	Quality, Finance and Performance Committee		1. Lessons learned following IG breaches are shared with all staff.	MA	Completed and ongoing.

Quality Directorate Risk Register December 2018/19

Strategic Objective 2018/19		Executive Lead	Link to Risk Register	Risks Identified		Date		Risk Rating (Initial)	Rating of Risk to Objective (Current)	Risk Rating (Target)	Identified Control			Control Gaps	Assurance		Assurance Gaps	Actions to Address gaps (controls and assurance)		
	What the organisation aims to deliver (outcome required	Board level lead responsible for achievement of the objective	All Risks	No	What could prevent us from meeting the objective?	Date added	Dated reviewed	Low/Moderate / High/ Extreme	Low/Moderate/ High/ Extreme	Low/Moderate / High/ Extreme	Primary Controls (closest to area of risk)	Secondary Controls (detective)	Tertiary Controls (includes external audits, internal audits, clinical audit, Royal College and other reviews)	Are the identified actions achieved?	Report to GB where controls and assurance around risk is presented	Board Committee where actions are monitored and assurance is provided to Board	Where we are not gaining effective evidence?	Further evidence/ actions to address control and assurance gaps	Responsible Officer (to deliver specific action)	Timescale for achievement
Objective 1: Developing models of care to support people out of hospital																				
Governing Body Sub-Committee: Joint Clinical Executive Committee																				
	Chief Nurse		Q1a	**Patient Safety/ Care - Respiratory** IF there is a lack of capacity and infrastructure to deliver holistic, high quality respiratory services across primary and secondary care. THEN patients diagnosed with respiratory conditions will not receive the appropriate level of advice and support to manage their condition. RESULTING IN an increasing number of patients with respiratory conditions attending hospital.	19.05.16	10.01.19	**8 (High)**	**16 (Extreme)**	**6 (Moderate)**	1. Respiratory action plan implemented by the South East Essex 2. Respiratory Network who monitor progress and blockages in the system. 3. CCG clinical executive committee have sight of the action plan and are kept up to date on how the actions are progressing. 4. Joint QIPP scheme with SUHFT. 5. The action plan is embedded within the CEC and A&E Delivery Board Agendas. 5. Joint QIPP with EPUT and SUHFT monitored via the Joint QIPP Board. 6. Implementation of clear out patients appointments (not previously in place). 8. Detailed Work plan developed and monitored via Joint QIPP to address key areas of service delivery i.e.. enhanced community capacity reducing acute activity).	1. CEC minutes to GB (bi monthly). 2. Monthly QIPP reports to QFC an FRG minutes to GB (bi monthly)		First appointment wait for routine follow ups in excess of 30 weeks. No new funding to transform current services leading to potential financial risk whilst transition takes place. Levels of emergency admissions remain high. Significant variation in primary care around significant capability and confidence. Challenges in workforce within SUHFT.		Quality, Finance and Performance Committee			LS	
	Chief Nurse		Q1b	**Patient Care/ Safety - PUPoC**. IF families are not receiving appropriate payment, or receiving late or delayed payments due to CHC retrospective reviews not being completed on time THEN families cannot provide the necessary support they wish to and family members condition may worsen. RESULTING IN delayed care being received, conditions of patient worsening because of unnecessary delays in care input, families being in an unnecessary poor financial position.	06.10.16	10.01.19	**15 (Extreme)**	**8 (High)**	**3 (Low)**	1. Logging applications for retrospective review which are outside the Arden contract. 2. Essex wide DONS meetings to discuss future options to manage PuPOC. 3. NHSE currently engaged with investigations of Arden GEM management of CHC services. 4. Local received requests for review against PuPOC managed through complaints/CHC team. 5. Agreement reached in May 17 that Southend CCG CHC team would review future retro claims. 6. Dedicated team at Southend CCG reviewing retrospective claims.	1. Monthly workforce reports to QFP 2. Minutes of FRG and QFP to GB bi-monthly.		Strategic approach to PUPoC in STP/Greater Essex.		Quality, Finance and Performance Committee		1. Decision to be made via Essex Executive Nurses on preferred option as to future PUPoc model 20.1.17. 2. Paper being developed by MG to go to DON for approval to go to GB. Update 27.09.18: Initial PUPoC data to inform reporting, from SCCG, now agreed. 1st Draft anticipated at October QFP	LS	
	Chief Nurse		Q1c	**Patient Care / Safety** IF the trust SHMI remains above the national average. THEN there is an elevated risk of hospital deaths. RESULTING IN unnecessary deaths within the hospital environment, lack of confidence in hospital care, poorer outcomes for patients, regulatory intervention.	01.08.17	10.01.19	**16 (Extreme)**	**10 (High)**	**3 (Low)**	1. Detailed improvement plan implemented by SUHFT: 2. CCG has identified concerns about the current SHMI rate with the provider. Commissioners and NHSE through the Quality Surveillance Group. 3. Independent audit of mortality through Dr Foster 4. Strengthen of the governance of the hospital Mortality Surveillance Group, including standardised structure for reporting and monitoring 5. CCG clinical representation at the Trust mortality group Review of coding in accordance with good practice rules. 6. Board to Board Mortality meetings attended by the CCG/SUHFT to commence on 11/10/17. 7. Dedicated project nurse supports the implementation of the SHMI action plan. 8. Bi weekly meetings with the Trust and CCG attended by the Chief Nurse commenced on 2/10/17. 9. Associate Medical Director appointed to focus on hospital mortality and implementation of the improvement plan.	1. NHSI Improvement plan monitored through NHSE, NHSI and SUHFT CQRG. CQRG minutes to Southend CCG GB bi monthly. 2. SUHFT Medical Director and Managing Director reported to CEC on 17.08.17 an improvement in activity. CEC minutes to GB bi monthly. 3. Chief Nurse reports monthly to Joint CEC. Minutes to GB. Action plan to be agreed across system to be signed off through CEC. 4. Medical Director and Managing Director have reported improvement activity to CEC on 17.8.17. 5. SHMI report to QGC bi monthly. Minutes to GB (bi monthly).				Quality, Finance and Performance Committee, Governing Body		De-escalated from 20 as SHMI score is now back within normal tolerances. CCG keeping a watching brief to ensure this does not escalate in the near future	Joint Committee	
	Chief Nurse		Q1d	**New Risk:** IF the Personalised Health Budget process is not implemented appropriately, THEN there is a risk that fewer PHB applications will be commenced.	28.12.18	10.01.19	**16 (Extreme)**	**16 (Extreme)**	**6 (Moderate)**	1. Liaison with NHSE National Lead for PHB to develop BAU approach to CHC Dom Care 2. NHSE Reporting requires all CHC Dom Care to be via PHB by April 2019. 3. CHC Action Plan being developed by 15th January 2019 4. Broader organisational discussion required as PHB affects all specialities; not just CHC. NHSE Expectation is that any and all opportunities to develop PHB should be explored and available to patients with identified health need. Paper to CMT in January.								MG	
Objective 2: Delivering local and national priorities, ensuring earned autonomy from regulators																				
Governing Body Sub-Committee: Quality, Finance and Performance																				
	Chief Nurse		Q2a	**Patient Safety/ Care - Safeguarding** IF there is lack of robustness in regard to Safeguarding protocols in the provider organisation. THEN there is a risk of failure in identifying children in need or at significant risk. RESULTING IN children being placed at unnecessary risk, children being at an increased probability of being abused, lack of confidence in the system.	03.11.15	10.01.19	**16 (Extreme)**	**4**	**3 (Low)**	1. Paediatric Health Visitor visits A&E each week day to provide liaison between acute and community services. 2. KPIs in place for Look After Children & Safeguarding. 6/12ly report & KPIs, access to training & exception reporting to the CQRG 1/12ly. 3. Recovery plan in place addressing training needs & targets. 4. Verbal & written reports from the provider to the QFP 1/4. 5. SUHFT annual Safeguarding report & 1/4ly Quality Report to QFP. 6. Serious Case Reviews Reports disseminated to all Safeguarding teams. 7. SUHFT have adopted new reporting systems. 8. CQC inspection across all health partners in Southend locality. 9. Policies and procedures are in place.	1.CQRG minutes to QFP monthly. 2. FP minutes to the Governing Body bi-monthly. 3. Summary of CQC Inspection Report to GB in September 2016. 4. Joint targeted area inspection included CQC scrutiny of ED and maternity services March 2018. No priority actions identified. 5. Published report will be available on CCG website and shared with all stakeholders.		Not all staff have the appropriate knowledge skill mix and competencies appropriate to their roles and responsibilities to safeguard children.		Quality, Finance and Performance		Training to be delivered to staff in line with Safeguarding children and young people: roles and competences for health care staff (Intercollegiate Document). Training compliance has improved but remains below KPI target 90%.	SC	
	Chief Nurse		Q2b	**CHC Assessments** IF there are delays in reviewing CHC patients due to the increasing demand on the service. THEN the CCGs will be unable to meet the timescales laid out in the National Framework for completing CHC cases. RESULTING IN patients not receiving funding and potentially the care they require on a timely basis, and reputational risk to the CCGs.	06.10.16	10.01.19	**16 (Extreme)**	**9 (High)**	**6 (Moderate)**	1. Additional agency staff sourced as an when required to prevent backlog of assessments. 2. Performance reports monitoring compliance against the 28 day standard.								MG	
	Chief Nurse		Q2c	**New Risk: CCG Complaints and SI Processes** IF the CCGs complaints and SI policies and processes are not complied with, THEN poor clinical / managerial practice can be overlooked, RESULTING IN risks to patient safety, experience, CCG / provider reputation and potential legal challenge.	28.12.18	10.01.19	**16 (Extreme)**	**8 (High)**	**3 (Low)**	1. Complaints Policy and Procedures reviewed and consistent across both CCGs. 2. Joint Complaints and Quality Team across both CCGs. 3. All historic SCCG complaints / SIs that require investigation / response are being dealt with. 4. Complaints training provided to all CCG staff.		1. Complaints and SI investigation undertaken by external contractor. 2. Complaints and SI Audit undertaken. 3. Detailed investigation undertaken by an independent contractor in relation to two complaints.		Escalated by QFP to GB.	QFP		1. Line Managers need to ensure that their staff are aware of the Complaint Policy and Procedures and what to do in the event of receiving a complaint.	LT	Feb-19
	Chief Nurse		Q2d	**New Risk: Nursing Homes, Residential Homes, Hospices** IF nursing homes, residential homes, or hospices do not identify and respond to the needs of patients appropriately, THEN patients will experience poor quality of care, RESULTING IN potential harm to patients and reputational damage to the CCG and relevant providers.	28.12.18	10.01.19	**15 (Extreme)**	**10 (High)**	**6 (Moderate)**	Regular scrutiny of CQC outcome assessments inform potential areas of risk. Working in partnership with ECC and SBC to undertake quality visits to provide assurance, action plans put in place to monitor and review progress.				Escalated by QFP to GB.	QFP		Review of education and training provision within all residential settings to maximise potential of staff capability. Enabling strong communication between the homes and the CCG to enable them to request advice/assistance as indicated by the emerging needs.	DB	
Objective 3: Strong voice in system wide plans																				
Board Committee: Quality, Finance and Performance																				
None																				

Strategy and Planning Directorate Risk Register December 2018/19

Strategic Objective 2018/19		Executive Lead	Link to Risk Register	Risks Identified			Date		Risk Rating (Initial)	Rating of Risk to Objective (Current)	Risk Rating (Target)	Identified Control			Control Gaps	Assurance		Assurance Gaps	Actions to Address gaps (controls and assurance)		
	What the organisation aims to deliver (outcome required	Board level lead responsible for achievement of the objective	All Risks	No	What could prevent us from meeting the objective?		Date added	Date reviewed	Low/Moderate/ High/ Extreme	Low/Moderate/ High/ Extreme	Low/Moderate / High/ Extreme	Primary Controls (closest to area of risk)	Secondary Controls (detective)	Tertiary Controls (includes external audits, internal audits, clinical audit, Royal College and other reviews)	Are the identified actions achieved?	Report of Board where controls and assurance around risk is presented	Board Committee where actions are monitored and assurance is provided to Board	Where we are not gaining effective evidence?	Further evidence/ actions to address control and assurance gaps	Responsible Officer (to deliver specific action)	Timescale for achievement
Objective 1: Developing models of care to support people out of hospital																					
Governing Body Sub-Committee: Joint Clinical Executive Committee																					
No directorate risks raised under this objective.																					
Objective 2: Delivering local and national priorities, ensuring earned autonomy from regulators																					
Governing Body Sub-Committee: Quality, Finance and Performance																					
	Director of Strategy and Planning		SP 2a	**New Risk: IT programmes** IF STP wide IT programmes are not governed and assured appropriately. THEN there is a risk that IT solutions are implemented that are not in the best interests of the CCGs or that are not fit for purpose. RESULTING IN financial and reputational loss and loss of IT continuity.			28.12.18	10.01.19	**8 (High)**	**8 (High)**	**3 (Low)**	1 . Improvement Plan and Operational Plan Performance Management in place.				AO Update report, IT Update report	QFP		1. Increased assurance around STP wide IT programme 2. Clear sight of programmes and outcomes/ benefits for add to assurance	PK	1. Jan 19 2. Feb 19
	Director of Strategy and Planning		SP 2b	**New Risk: IT Migration** IF Migration to Arden/ Gem does not take place on time or without failure. THEN there is a risk to continued service delivery. RESULTING IN lack of continuity of service and potential loss of record and financial implications.			28.12.18	10.01.19	**12 (High)**	**12 (High)**	**3 (Low)**	1. Project Plan for the movement of services over in place. 2. Performance management of project plan in place with CCG lead. 3. QFP over view of move/ risks and mitigations for assurance via regular reporting in place.	1. GB overview of progress for assurance			IT update report	QFP			PK	
	Director of Strategy and Planning		SP 2c	**IT Failure** IF there is a failure of the key IT systems including the shared drive, internet or finance system and key information systems. THEN there will be a sever negative effect on business processes. RESULTING IN financial and reputational loss and loss of IT continuity.			28.01.16	10.01.19	**8 (High)**	**8 (High)**	**6 (Moderate)**	1. 2017/18 Business Continuity Plan in place. 2. Disaster Recovery Plan in place. 3. IT server systems located off site. 4. IT nightly backup systems in place. 5. ICT Collaborative Forum (mthly)	1. Malware systems run constantly in the background providing security of data.			IT update report, Policy Assurance Group on Business Continuity Plans	QFP			PK	
	Director of Strategy and Planning		SP 2d	**New Risk: GDPR (date protection)** IF the CCG fails to understand its responsibilities under the GDPR. +F17THEN the CCG may not comply fully with all requirements. RESULTING IN financial penalties and reputational damage.			28.12.18	10.01.19	**12 (High)**	**12 (High)**	**3 (Low)**	1. CCG lead for GDPR in place 2. Regular updates in place to Audit Committee for assurance.	1. Scrutiny of regulations in place to take into account any changes in the law.			Governance Report	QFP		1. Increased awareness amongst all senior staff in the CCG on responsibilities and possible consequences.	PK	1. Feb 19
	Director of Strategy and Planning		SP 2e	**New Risk: Improvement Plan** IF the CCG fails to deliver against its Improvement Plan THEN NHSE may not lift special measures RESULTING IN continued reg scrutiny management distraction and poor performance			28.12.18	10.01.19	**12 (High)**	**12 (High)**	**3 (Low)**	1. Regular reporting on performance to Governing Body in place. 2. Regular reporting to on performance to CMT in place. 3. Regular reporting on performance to QFP in place. 4. Director lead for Improvement Plan. 5. Progress scrutinised by Improvement Director (NHSE).	1. NHSE invited to CMT on a regular basis to provide assurance and guidance on progress. 2. Evidence collection on actions to provide assurance of embedding in CCG working practices.			Improvement Plan Update Report	QFP		1. Triangulation of evidence to ensure it covers the actions and is fit to submit for scrutiny.	SP	1. Dec 19
	Director of Strategy and Planning		SP 2f	**New Risk: HR records and processes** IF the organisation does not maintain robust and complete HR records. THEN HR decisions could be open to challenge and there is no organisational record of decisions made. RESULTING IN non adherence to employment law and financial reputational and legal exposure.			28.12.18	10.01.19	**12 (High)**	**9 (High)**	**3 (Low)**	1. Plan devised and agreed on expectations an actions to provide and hold HR records. 2. Staff training programme in place to provide training on policy adherence and action.		Internal HR Audit		Integrated Performance Report	QFP		1. Audit on HR records and their suitability now and for the future	MA	1. Mar 19
	Director of Strategy and Planning		SP 2g	**New Risk: Communications and engagement** IF the CCG does not consult and engage with the public, its partners and other stakeholders, or fails to conduct appropriate impact assessments (equality, quality and privacy) when undertaking service changes, THEN this may lead to poor decision making, impacting on buy in to our strategy and diminishing organisational direction. RESULTING IN failure to deliver our Operational Plan.			28.12.18	10.01.19	**12 (High)**	**6 (Moderate)**	**4 (Moderate)**	1. Communication and Engagement strategy produced and agreed at GB. 2. Regular communications sessions with GPs, staff and stakeholders in place via comms team. 3. Regular updates on progress against CCG strategic directions and Operational Plan in place.	1. Engagement with NHSE on CCG plans and direction of travel through regular assessment sessions.			Integrated Performance Report	QFP, PCC		1. Need to develop a strategic approach to engagement and how we influence our partners and key stakeholders positively.	CR	1. Mar 19
	Director of Strategy and Planning		SP 2h	**New Risk: Governing Body and Committee Effectiveness** IF the Governing Body and principal Governing Body Committees are ineffective or fail to co-ordinate their assurance roles, Then the CCGs are at risk of breaching their statutory duties and delay implementation of strategic and transformation plans, RESULTING in loss of reputation, impact on patient care and stakeholders, potential legal challenge and financial implications.			28.12.18	10.01.19	**15 (Extreme)**	**9 (High)**	**3 (Low)**	1. Review of committees across both CCGs undertaken. 2. Governing Body development programme commenced, supported by GGI. 3. Governing Body and Committee effectiveness surveys undertaken and results presented at a public Governing Body meeting. 4. OD Strategy reviewed to include GB and Committee members development.	1. New Executive Team members sharing lessons learned from other organisations.	GGI Review. Governance audit - Mazars		Committee effectiveness report to GB.	QFP, Audit Committee			MA	
Objective 3: Strong voice in system wide plans																					
Board Committee: Quality, Finance and Performance																					

	Director of Strategy and Planning		SP 3a	**New Risk: JCT Governance** IF the JCT Governance is not well defined understood or followed. THEN decisions could be taken without appropriate GB oversight and sign off. RESULTING IN failure to comply with our Constitution inappropriate decision making and financial reputational risk.	28.12.18	10.01.19	**9 (High)**	**9 (High)**	**3 (Low)**	1. CCG contributes to discussion at a strategic level via STP membership. 2. CCG Governance process refresh in progress to ensure it is fit for purpose for the future.	1. CCG discussions with NHSE to ensure consistency across the patch in terms of governance activity.		resource in governance diminished	AO Update Report	QFP, AC		1. CCG have clear plans for its direction of travel and how its governance systems are going forward in the future.	CD	1. Feb 19
	Director of Strategy and Planning		SP 3b	**New Risk: SUHFT referral to Secretary of State** IF the referral the Secretary of State is upheld. THEN the acute reconfiguration will be paused an/or disrupted. RESULTING IN poor service delivery, quality concerns and MSB management attention being diverted away from front line delivery.	28.12.18	10.01.19	**12 (High)**	**12 (High)**	**4 (Moderate)**	1. CCG AO and Trust CEO in regular dialogue around situation and possible action. 2. Action plan I place for acute reconfiguration. 3. Performance management of reconfiguration plan in place and scrutinised by JCT. 4. CCG contract meetings in place to assure front line delivery and focus				AO Update Report	QGP, CEC, AC			CD	

Primary Care and Operations Directorate Risk Register December 2018/19

Strategic Objective 2018/19		Executive Lead	Link to Risk Register	Risks Identified		Date		Risk Rating (Initial)	Rating of Risk to Objective (Current)	Risk Rating (Target)	Identified Control			Control Gaps	Assurance		Assurance Gaps	Actions to Address gaps (controls and assurance)		
	What the organisation aims to deliver (outcome required	Board level lead responsible for achievement of the objective	All Risks	No	What could prevent us from meeting the objective?	Date added	Date reviewed	Low/Moderate/ High/ Extreme	Low/Moderate/ High/ Extreme	Low/Moderate/ High/ Extreme	Primary Controls (closest to area of risk)	Secondary Controls (detective)	Tertiary Controls (includes external audits, internal audits, clinical audit, Royal College and other reviews)	Are the identified actions achieved?	Report of Board where controls and assurance around risk is presented	Board Committee where actions are monitored and assurance is provided to Board	Where we are not gaining effective evidence?	Further evidence/ actions to address control and assurance gaps	Responsible Officer (to deliver specific action)	Timescale for achievement
Objective 1: Developing models of care to support people out of hospital																				
Governing Body Sub-Committee: Joint Clinical Executive Committee																				
None																				
Objective 2: Delivering local and national priorities, ensuring earned autonomy from regulators																				
Governing Body Sub-Committee: Quality, Finance and Performance Committee																				
		Director of Primary care and Operations			**Patient Safety/ Care**. IF there is a lack of engagement from GP and member practices in strategy and transformation. THEN some GPs will be unaware of the strategic direction of health/ social care services across the locality. RESULTING IN a negative impact on patient care, individual GPs being left behind in terms of strategic and operational direction and actions, inconsistent service provision across SE Essex.	15.04.15	10.01.19	**8 (High)**	**8 (High)**	**6 (Moderate)**	1. Attendance register signed by attendees at all LCGs. 2. Clinical leads in place for all projects. 3. Clear project governance that ensures clinical discussion at key stages. 4. Finance monitor the attendance of partners via claims monthly basis. 5. Lead GPs are directly engaged with integrated work streams. 6. LCG's monthly (CPR). 7. Integrated work stream reports presented at weekly CEC. 8. Action plans monitored by CEC. 9. CEC reviewing practice level data post practice visit communications. 10. PCCC mthly review of activity against GPFV delivery plan. 11. Bi monthly CP&R LCGs and Joint LCG. 12. Development of Practice level dashboard to monitor performance/activity and target practice visits for top 6 practices including clinical and managerial executive support.	1. Minutes of the Joint CEC, LCG (CPR) and PCCC go to the 2. Governing Body bi-monthly.				Joint CEC		1. Ongoing monitoring of joint meeting attendance. 2. Targeted visits to those practices who aren't engaging. 3. Procurement underway to invest in primary care at scale across localities which incentivising practices to engage in the CCG Primary 4. Care Strategy and Transformation.	JS	
		Director of Primary care and Operations			**New Risk: Patient Care/ Safety - Cancer** IF the CCG cannot support the Trust to successfully manage and meet the targets relating to Cancer Services. THEN patients will not receive the service expected in the times frame required. RESULTING IN danger to patient care, unnecessary waits for treatment, possibly more invasive treatment than would have been needed.	28.12.18	10.01.19	**12 (High)**	**12 (High)**	**6 (Moderate)**	1. Regular performance updates as part of the CCGs Performance Reporting. 2. Regular contract review meetings. 3. Recovery Plans for Cancer services	1. Reporting to Governing Body			Integrated Performance Report	QFP			Joint Committee	
		Director of Primary care and Operations			**New Risk: SystemOne Usage in General Practice** IF practice staff are not appropriately trained to use SystemOne, THEN there is potential for flags generated by the system to not be actioned, RESULTING in risks to patient safety.	28.12.18	10.01.19	**15 (Extreme)**	**12 (High)**	**6 (Moderate)**									PK	
Objective 3: Strong voice in system wide plans																				
Governing Body Sub-Committee: Quality, Finance and Performance Committee																				
None																				

Out of Hospital Care and Partnerships (SCCG) Directorate Risk Register December 2018/19

Strategic Objective 2018/19		Executive Lead	Link to Risk Register		Risks Identified	Date		Risk Rating (Initial)	Rating of Risk to Objective (Current)	Risk Rating (Target)	Identified Control			Control Gaps	Assurance		Assurance Gaps	Actions to Address gaps (controls and assurance)		
	What the organisation aims to deliver (outcome required	Board level lead responsible for achievement of the objective	All Risks	No	What could prevent us from meeting the objective?	Date added	Date reviewed	Low/Moderate / High/ Extreme	Low/Moderate/ High/ Extreme	Low/Moderate/ High/ Extreme	Primary Controls (closest to area of risk)	Secondary Controls (detective)	Tertiary Controls (includes external audits, internal audits, clinical audit, Royal College and other reviews)	Are the identified actions achieved?	Report of Board where controls and assurance around risk is presented	Board Committee where actions are monitored and assurance is provided to Board	Where we are not gaining effective evidence?	Further evidence/ actions to address control and assurance gaps	Responsible Officer (to deliver specific action)	Timescale for achievement
Objective 1: Developing models of care to support people out of hospital																				
Governing Body Sub-Committee: Joint Clinical Executive Committee																				
		Director of Partnerships - Southend			**Demand Management - ASD** IF there are not enough ASD assessments commissioned for the identified waiting list and administration demands. THEN there will be a failure to manage current and future demand RESULTING IN inability to provide timely diagnosis for patients with suspected ASD, increase in complaints and loss of reputation.	08.10.15	10.01.19	**15 (Extreme)**	**6 (Moderate)**	**4 (Moderate)**	1. Escalate risks/concerns through contractual review groups where necessary. 2. Monthly report to QFP. 3. Regular analysis of activity and performance. 4. Additional diagnostic assessments commissioned. Total of 105 commissioned in 17/18 to be delivered by August 2018. 5. Joint (with SCCG) commissioning solution proposal in development business case planning for implementation in 1920. 6. CCG implemented business apprentice to support with effect from 29/01/18 for administrative function at SUHFT for admin management of ASD list and transfer of cases to diagnostic problems.	1. Formal interim contract in place with the Lorna Wing including monitoring. 2. PMO reported to QFP 3. QFP Minutes to GB bimonthly.		Long term solution not yet in place. Management of contractual arrangements with SUHFT to support their gap in delivery for transfer of cases to diagnostic providers. Lack of qualified workforce to delivery commissioned under 5 ASD assessments (42 for SE) due to retirement ADOS trained paediatrician.		Quality, Finance and Performance		1. Develop substantive Business Case for substantive ASD assessment service through Paediatric Transformation and expert commissioning recourse expected by July 2018. 2. Under delivery of contractual ASD under 5 assessments raised as AOB at SUHFT Technical Contract meeting on 12/03/18 awaiting SUHFT formal response.	RG	
		Director of Partnerships - Southend			**New Risk: SEND** Failure to comply with the SEND statutory duties. Unable to demonstrate robust health commissioning procedures to facilitate compliance. Inability of CCG to ensure timely, input from health to panel assessments.	28.12.18	10.01.19	**12 (High)**	**9 (High)**	**4 (Moderate)**	1. Self Assessment Framework in place. 2. Commissioning process in place across South Essex. 3. Pro forma compliance test completed. 4. POETS monitoring with LA. 5. Member of EHC review monitoring panel. 6. SEND updates to QFP quarterly. 7. Essex wide SEND strategic governance group bi monthly CCG are members updates are fed into quarterly report to QFP.		SEND Inspection	Recommendations made following SEND inspection - see action plan.		Quality, Finance and Performance			RG	
Objective 2: Delivering local and national priorities, ensuring earned autonomy from regulators																				
Governing Body Sub-Committee: Quality, Finance and Performance																				
None																				
Objective 3: Strong voice in system wide plans																				
Governing Body Sub-Committee: Quality, Finance and Performance																				
None																				

Out of Hospital care and Partnerships (CP&R) Directorate Risk Register December 2018/19																				
Strategic Objective 2018/19		**Executive Lead**	**Link to Risk Register**	**Risks Identified**			**Date**		**Risk Rating (Initial)**	**Rating of Risk to Objective (Current)**	**Risk Rating (Target)**	**Identified Control**			**Control Gaps**	**Assurance**		**Assurance Gaps**	**Actions to Address gaps (controls and assurance)**		
	What the organisation aims to deliver (outcome required	Board level lead responsible for achievement of the objective	All Risks	No	What could prevent us from meeting the objective?	Date added	Date reviewed	Low/Moderate / High/ Extreme	Low/Moderate/ High/ Extreme	Low/Moderate / High/ Extreme	Primary Controls (closest to area of risk)	Secondary Controls (detective)	Tertiary Controls (includes external audits, internal audits, clinical audit, Royal College and other reviews)	Are the identified actions achieved?	Report of Board where controls and assurance around risk is presented	Board Committee where actions are monitored and assurance is provided to Board	Where we are not gaining effective evidence?	Further evidence/ actions to address control and assurance gaps	Responsible Officer (to deliver specific action)	Timescale for achievement
Objective 1: Developing models of care to support people out of hospital																				
Governing Body Sub-Committee: Joint Clinical Executive Committee																				
None																				
Objective 2: Delivering local and national priorities, ensuring earned autonomy from regulators																				
Governing Body Sub-Committee: Quality, Finance and Performance																				
		Director of Partnerships - CPR			**Financial Stability** - Prescribing. Risk of failure to achieve financial balance due to overspends within the prescribing budget.	08.09.15	10.01.19		**12 (High)**		1. QIPP projects in place focusing on key areas. 2. 1/12ly report on all related areas of QIPP go to the Drugs & Therapeutics Committee. 3. 1/12ly Drugs & Therapeutics Committee. 4. Monthly updates to F&P Committee 5. 1/12ly PMO tracker report to Drugs & Therapeutics Committee. 6. Quarterly meetings with Finance Officer. 7. Bi weekly meetings with PMO leader. 8. Monthly reports to FPC.	1. Minutes of the Drugs & Therapeutic Committee go to the Quality & Governance Committee. 2. PMO tracker reports go to the Transformation & Sustainability Committee. 3. F&P Minutes to GB (bi-monthly).				Quality, Finance and Performance Committee			ETG/KB	
Objective 3: Strong voice in system wide plans																				
Governing Body Sub-Committee: Quality, Finance and Performance																				
None																				

Finance Directorate Risk Register December 2018/19																				
Strategic Objective 2018/19		**Executive Lead**	**Link to Risk Register**	**Risks Identified**			**Date**		**Risk Rating (Initial)**	**Rating of Risk to Objective (Current)**	**Risk Rating (Target)**	**Identified Control**			**Control Gaps**	**Assurance**		**Assurance Gaps**	**Actions to Address gaps (controls and assurance)**	
	What the organisation aims to deliver (outcome required	Board level lead responsible for achievement of the objective	All Risks	No	What could prevent us from meeting the objective?		Date added	Date reviewed	Low/Moderate / High/ Extreme	Low/Moderate/ High/ Extreme	Low/Moderate / High/ Extreme	Primary Controls (closest to area of risk)	Secondary Controls (detective)	Tertiary Controls (includes external audits, internal audits, clinical audit, Royal College and other reviews)	Are the identified actions achieved?	Report of Board where controls and assurance around risk is presented	Board Committee where actions are monitored and assurance is provided to Board	Where we are not gaining effective evidence?	Further evidence/ actions to address control and assurance gaps	Responsible Officer (to deliver specific action)	Timescale for achievement
Objective 1: Developing models of care to support people out of hospital																				
Governing Body Sub-Committee: Joint Clinical Executive Committee																				
No directorate risks raised.																				
Objective 2: Delivering local and national priorities, ensuring earned autonomy from regulators																				
GB Sub-Committee: Quality, Finance and Performance Committee																				
		Chief Finance Officer			**New Risk: Finance - uplift** IF the CCGs to not receive adequate financial uplifts for budgets. THEN there is danger the organisations will not meet their financial obligations and/ or meet their statutory control totals RESULTING IN possible further savings needed, increased financial instability, increased focus ion finance and away from service intervention and delivery.		28.12.18	10.01.19		**12 (High)**		1. Financial recovery Plans in place with close scrutiny from the Financial Recovery Group (FRG) 2. QFP receive monthly finance reports against financial plan 3. Regular meeting with NHSE on financial position of the CCGs for assurance of financial position but also discussion on future financial needs. 4. Monthly reports to NHSE		Internal and External Audit of financial systems and processes						LB	
Objective 3: Strong voice in system wide plans																				
GB Sub-Committee: Quality, Finance and Performance Committee																				
No directorate risks raised.																				