

BOARD ASSURANCE FRAMEWORK

Amended Following September 2015 Governing Body Meetings

VERSION 2.7 – SEPTEMBER 2015

INTRODUCTION

1. As a Clinical Commissioning Group (CCG) we have identified various risks, many of which are low level and are operationally managed. This document highlights the top strategic risks facing us as an organisation and, therefore, the scores for these risks tend to be higher, at least at the start of the year.
2. The CCG is part of a collaborative arrangement with other CCGs in North West London comprising Central London, West London, Hammersmith & Fulham, Hounslow and Ealing CCGs. The CCGs have worked together to identify a common set of risks and to develop common approaches to their management, as appropriate. Some risks are more pertinent to some CCGs than others.
3. Workshops have taken place with each CCG Governing Body to identify the strategic objectives and priorities for the year. The outputs were mapped to the set of identified risks from 2014/15, as well as new risks identified during governing body and committee discussions. This Board Assurance Framework (BAF) takes those key risks to the delivery of the CCG's strategic objectives and 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. It includes an action plan to further reduce the risks and an assessment of current performance.
4. The table below sets out the strategic objectives and lists the various risks that relate to them.

CCG Objective	Description of Risk Identified	Initial Score	Current Score	Last Review
Objective 1: Enabling people to take more control of their health and wellbeing	1 – If we do not successfully empower patients and change behaviours, activity will continue to grow and the system will become unsustainable.	16	16	October 2015
Objective 2: Securing quality healthcare services and improved outcomes for the people we commission services for	2 – Safeguarding children: Risk that we do not comply with the Children Act and the NHSE assurance framework, due to complexities of multi-agency working, especially in the case of looked after children placed out of borough, as well as the way tier 4 child and adolescent mental health services (CAMHS) are commissioned, leading to a child being seriously harmed.	15	15	October 2015
	3 – Safeguarding adults: Risk that we do not sustain compliance with the Care Act and the NHSE assurance framework across all the services that we commission, leading to an adult being seriously harmed.	16	15	October 2015
	4 - Chelsea and Westminster Hospital NHS Foundation Trust: Risk that the acquisition of West Middlesex Hospital does not realise the expected benefits for patients.	16	12	October 2015
	5 – Imperial: Risk that the Trust does not deliver quality and performance requirements and strategic change to the require timescales, particularly in relation to: <ul style="list-style-type: none"> • Accident & Emergency performance • Non-elective pathway changes • Referral to Treatment performance • Outpatients 	16	16	October 2015
	6 - London North West NHS Trust: Risk that the Trust (incorporating Ealing Hospital) does not deliver quality and performance requirements to the required timescales, particularly in relation to: <ul style="list-style-type: none"> • Cancer • Staffing levels • Trust finances 	20	20	October 2015
	7 - Central London Community Healthcare NHS Trust: Risk that the organisation is not delivering strategic change and operational performance, with a focus on safe services during the procurements of care home services, and transformation of community nursing	20	20	October 2015
	8 - West London Mental Health Trust: Risk that the organisation is not well positioned to deliver strategic change and operational performance.	16	12	October 2015

CCG Objective	Description of Risk Identified	Initial Score	Current Score	Last Review
	<p>9 - Central & North West London Trust: Risk that the Trust does not deliver quality and performance requirements and strategic change to the required timescales, particularly in relation to:</p> <ul style="list-style-type: none"> • Staffing levels • Financial position • Service transformation and capacity to deliver change <p>Bed capacity – Care Quality Commission Report</p>	20	20	October 2015
	<p>10 - London Ambulance Service: Risk that the workforce is not in place to deliver the high quality, value for money service required, leading to delays in attending patients and risk of serious patient harm.</p>	16	16	October 2015
	<p>11 – Care homes and care packages: Risk that quality and financial challenges in care providers (such as care homes, supported housing, domiciliary care or other care packages commissioned by CCGs) leads to patient harm and/or safeguarding concerns, as well as to pressure on Accident & Emergency and non-elective activity.</p>	20	20	October 2015
	<p>12 – Federations: Risk that Primary care is unable to deliver increased activity due to organisational and workforce issues (includes implications of working at scale and establishing GP federations).</p>	16	16	October 2015
	<p>13 – Primary care co-commissioning: Risk that the structures and behaviours established to jointly commission primary care with NHS England:</p> <ul style="list-style-type: none"> • do not enable us to commission the change required to deliver our strategy • adversely affect relationships with member practices • create significant conflicts of interest • there is not the finance or capacity to deliver <p>leading to challenges in delivering the change to services in our plans.</p>	16	16	October 2015

Objective 1: Enabling people to take more control of their health and wellbeing

Director lead: Managing Directors

CCG Objective	Description of Risk Identified	Initial Score	Current Score	Last Review
Objective 3: Enhancing the organisation's culture – developing people, processes and systems to help deliver high quality commissioning	14 - If we do not engage member practices, the LMC and other partners in the change programmes, we will not be able to realise the intended quality improvements.	16	16	October 2015
Objective 4: Establishing a collaborative and proactive culture with partners and the people we commission services for	15 – Conflicts of interest: Not managing conflicts of interest adequately leaves us open to challenge and reputational damage.	15	15	October 2015
	16 – Strategic change (workforce) : Risk that we do not have the required resources in place across the system to deliver strategic change including: <ul style="list-style-type: none"> - workforce to deliver new models of care - training and development for future workforce - organisational development programmes that challenge the status quo, communicate the change needed, shape the culture and values needed and empower staff - finances to fund transitional change IT systems that make good use of technology	16	16	October 2015
Objective 5: Planning, developing and delivering strategies and actions that reduce inequalities and improve health outcomes	17 – Strategic change (organisations): Risk that provider organisations are not able to support implementation of the strategic changes to acute services.	16	12	October 2015
Objective 6: Empowering staff to deliver our statutory and organisational duties	18 – Finance: Risk that we do not achieve our financial duties in 2015/16, as well as ensuring the longer term financial stability and security of the system, whilst remaining within the management spend budget.	15	15	October 2015

Risk 1: – If we do not successfully empower patients and change behaviours, activity will continue to grow and the system will become unsustainable.

Date last reviewed: September 2015

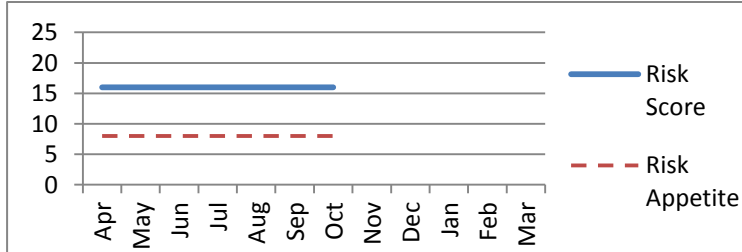
Risk Rating

(likelihood x consequence):

Initial: 4 x 4 = 16

Current: 4 x 4 = 16

Appetite: 2 x 4 = 8



Rationale for current score:

Empowering patients to make positive health choices is central to the CCG's plans to deliver high quality care closer to home, as essential to reducing the pressures on services and resources in the medium to longer term. However, this will require significant behavioural change and the current risk rating reflects the challenges in achieving this.

Rationale for risk appetite:

We want to reduce the likelihood of this risk happening, through developing more opportunities and support for patients to take more control of their health and wellbeing

Controls: (What are we currently doing about the risk?)

Culture change and leadership

WSIC Workforce Group: recruitment, training and development

PPG Development: investment in supporting effective development of PPGs

Systems

Co-design workstream as part of NWL Whole Systems programmes

Engaging communities: address inequalities, gather insight/ capture intelligence

Ensuring that all information shared with the public is easily accessible

Online appointment booking and e-Prescription services

Directory of local services – includes out of hours and pharmacy services

People

Self-Management Programmes for people with Long Term Conditions e.g. EPP

Primary Care Navigators (PCN)

Community Champions

Mitigating actions: (What more should we do?):

Mitigating actions	Timeline	Responsible
Culture change and leadership CCG clinical and managerial leaders taking a higher profile in promoting an integrated and sustainable approach to improve health and wellbeing, challenging behaviours and commitment where necessary	Ongoing	Chair/GB/MD
Systems Continue co-design work for care pathways, Out of Hospital Services, 7 Day Working and Whole Systems, both across NWL London and pan-London Whole Systems Task & Finish groups include patient representation Embedding self-care and self-management programmes in care planning Planned strategic approach to communicating key messages to patient and the public Community Sector capacity development programmes to support and deliver this agenda	Ongoing	MD/PH/DoST
People Promote existing and identify new budgets to commission self-management programmes. Peer Support, Mentoring and Champions Programmes PCN extended to cover under 50s and across all GP Networks Use winter planning to engage people in self-management communications	Ongoing	MD/PH
Health and Wellbeing Closer working with Public Health and the Local Authority on prevention/ early intervention	Dec 2015	MD/PH

Assurances: (How do we know if the things we are doing are having an impact?)

Better Care Fund: Assurance at Health & Wellbeing Boards

NHS England: regular assurance of CCG performance in this area

Gaps in assurance: (What additional assurances should we seek?)

- Matrix of outcomes and KPIs needs to be developed to provide assurance of progress across a range of indicators, including PPG development, success of self-care programmes, success of public health programmes, patient engagement in service transformation, etc.
- Assurance to CCG Governing Bodies that Better Care Fund spend is meeting care, quality and value for money expectations.
- Strengthened assurance of Public Health programme delivery

Current performance: (With these actions taken, how serious is the problem?)

Positive feedback at NHS England assurance, quarter 4, 2014/15. However, there are significant current gaps in outcome definitions, KPIs and monitoring to track improvements in mitigating this risk.

Additional Comments

1

Objective 2: Securing quality healthcare services and improved outcomes for the people we commission services for		Director lead: Director of Quality & Patient Safety																												
Risk 2 – Safeguarding children: Risk that we do not comply with the Children Act and the NHSE assurance framework, due to complexities of multi-agency working, especially in the case of looked after children placed out of borough, as well as the way tier 4 child and adolescent mental health services (CAMHS) are commissioned, leading to a child being seriously harmed.		Date last reviewed: September 2015																												
Risk Rating (likelihood x consequence): Initial: 3 x 5 = 15 Current: 3 x 5 = 15 Appetite: 2 x 5 = 10		Rationale for current score: Failure in this area would have an impact on vulnerable children within the community. This is a challenging control environment in the context of multi-agency working and the wider commissioning environment. Steps have been taken to reduce the likelihood of problems occurring, including action following the CAMHS review, as well as improvements in communication across health commissioners.																												
		Rationale for risk appetite: While the impact of failures could have a catastrophic impact on children, the aim is to reduce the likelihood of this occurring. However, risks can never be completely eliminated, as reflected in the risk appetite rating applied.																												
Controls: <i>(What are we currently doing about the risk?)</i> <ul style="list-style-type: none"> Leadership roles for safeguarding clearly defined within key providers and CCGs. Regular supervision of named professionals by the Designated professionals Engagement with the LSCB priorities and work streams LAC quarterly reports to the CCGs Partnership working with the LAs to improve the LAC work Challenge to partner agencies through the Safeguarding Children's Boards, where necessary Reporting systems for serious incidents to CCGs that identifies assurances. The reporting framework has been strengthened for providers via internal review, CQG scrutiny and CCG assurance using the outcomes framework. There are quarterly agenda reports by providers at CQG with exceptions as required monthly. There is a health lead on serious case reviews as they occur. CAMHS review report presented to CWHHE Quality and Safety Committee by Children's Commissioner and NHS England Designated LAC posts in place Perinatal commissioning across three boroughs 		Mitigating actions: <i>(What more should we do?)</i> <table border="1"> <tr> <td>Strengthen systems for monitoring the health plans of looked after children who have been placed in other boroughs. Report monthly to Hounslow CCG and review need for more frequent reporting to the other CCGs.</td> <td>Nov 15</td> <td>JW</td> </tr> <tr> <td>Ensure that there is an allocated budget to accommodate the assessments undertaken by out-of-borough teams, as well as the wider health needs of the children</td> <td>Nov 15</td> <td>JW</td> </tr> <tr> <td>Children's commissioner working with NHS England to improve access to CAMHS tier 4 beds and quality of tier 3 provision</td> <td>Oct 15</td> <td>MB</td> </tr> <tr> <td>Review process for DBS arrangements</td> <td>Sept 15</td> <td>MG</td> </tr> <tr> <td>Review commissioning of services to support those affected by FGM</td> <td>Oct 15</td> <td>MB/ TS</td> </tr> <tr> <td>Monitor safeguarding arrangements during the Chelwest acquisition of WMUH to ensure compliance with the Children Act 2004</td> <td>Sept 15</td> <td>JW</td> </tr> <tr> <td>Monitoring safeguarding workforce across providers, ensuring statutory requirements are being met</td> <td>Nov 15</td> <td>JW</td> </tr> <tr> <td>Highlight the Child Protection Information System (CP-IS) to the LSCBs to improve sharing information regarding child protection and LAC attending unscheduled care settings</td> <td>Oct 15</td> <td>JW</td> </tr> <tr> <td>Confirm funding arrangements for the Multi Agency Safeguarding Hub (MASH) health role</td> <td>Oct 15</td> <td>JW</td> </tr> </table>		Strengthen systems for monitoring the health plans of looked after children who have been placed in other boroughs. Report monthly to Hounslow CCG and review need for more frequent reporting to the other CCGs.	Nov 15	JW	Ensure that there is an allocated budget to accommodate the assessments undertaken by out-of-borough teams, as well as the wider health needs of the children	Nov 15	JW	Children's commissioner working with NHS England to improve access to CAMHS tier 4 beds and quality of tier 3 provision	Oct 15	MB	Review process for DBS arrangements	Sept 15	MG	Review commissioning of services to support those affected by FGM	Oct 15	MB/ TS	Monitor safeguarding arrangements during the Chelwest acquisition of WMUH to ensure compliance with the Children Act 2004	Sept 15	JW	Monitoring safeguarding workforce across providers, ensuring statutory requirements are being met	Nov 15	JW	Highlight the Child Protection Information System (CP-IS) to the LSCBs to improve sharing information regarding child protection and LAC attending unscheduled care settings	Oct 15	JW	Confirm funding arrangements for the Multi Agency Safeguarding Hub (MASH) health role	Oct 15	JW
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Assurances: <i>(How do we know if the things we are doing are having an impact?)</i> <ul style="list-style-type: none"> Quarterly written reports to CCG Quality committees with monthly verbal updates for exceptional issues. Minutes presented to Governing Body meetings. Reports to NHS England assurance meeting and Local Safeguarding Children's Board. 		Gaps in assurance: <i>(What additional assurances should we seek?)</i> <ul style="list-style-type: none"> The number of children placed out of Borough/changes to payment systems. Better mapping and clarity of transition from children's to adult services Safeguarding training compliance (as part of mandatory training) across all levels is not being reported consistently by providers. This must be addressed in the provider annual reports and evaluated by the CCG Safeguarding Annual Report Impact of HV commissioning transferring to LAs from NHSE 																												
Current performance: <i>(With these actions taken, how serious is the problem?)</i> Key risk factors are: Children placed out of borough with health needs requires the cooperation of LAC teams in other boroughs, children requiring CAMHS tier 4 treatment responsibility of NHSE		Additional Comments Risks around systems to monitor mobile families (Link to CP-IS)																												
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Objective 2: Securing quality healthcare services and improved outcomes for the people we commission services for

Director lead: Director of Quality & Patient Safety

Risk 3 – Safeguarding adults: Risk that we do not sustain compliance with the Care Act and the NHSE assurance framework across all the services that we commission, leading to an adult being seriously harmed.

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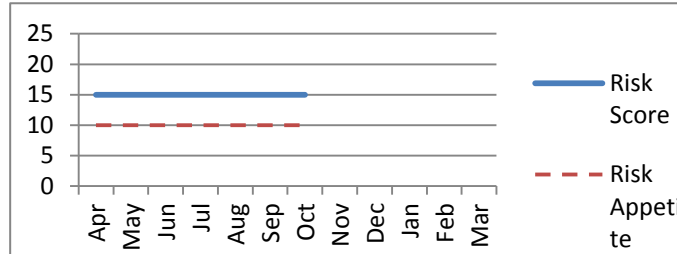
Risk Rating

(likelihood x consequence):

Initial: 4 x 4 = 16

Current: 3 x 5 = 15

Appetite: 2 x 5 = 10



Rationale for current score:

CCGs have implemented governance structures to exercise this function. However, legislation came into force in April 2015 which creates challenges, in the system, in terms of roles and responsibilities and this is reflected in the current risk rating.

Rationale for risk appetite:

While the impact of failures could have a catastrophic impact, the aim is to reduce the likelihood of this occurring. However, risks can never be completely eliminated, as reflected in the risk appetite rating applied.

Controls: (What are we currently doing about the risk?)

- Leadership roles for Safeguarding Adults have been reviewed within the CCGs to incorporate the requirements of the Care Act 2014, as well as the NHSE Accountability and Assurance Framework (2015)
- Established working relationship with Local Safeguarding Adults Board.
- Clear relationships with local authorities in relation to safeguarding
- Reporting systems have been developed to provide a framework for assurance to the CCGs.
- WL Mental Health Transformation work stream has been established to develop services for learning disability in line with 'Transforming Care'
- Safeguarding Adults audit tool completed in all CCGs and scrutinised by Safeguarding Adults Boards
- Fortnightly submissions to NHSE for 'Transforming Care', the national response to Winterbourne View Hospital
- Contracts and SLA's for Named GPs and Designated Doctors have been reviewed.

Mitigating actions: (What more should we do?):

Monitor impact of the MCA project being undertaken by Bucks University on behalf of the CCGs	Sept 15	JW
Work with providers to ensure that their safeguarding arrangements are in line with the Care Act 2014	Sept 15	JW
Maintain monthly tracking of 'Transforming Care' patients to identify any risks of non-compliance	Oct 15	MDs
Strengthen the assurance from Trusts in relation to safeguarding, MCA and 'Prevent' training through quarterly reporting within CQGs	Oct 15	JW
Review the role of CCGs in the DOLS system to ensure that patients are not being placed at risk	Oct 15	JW
Review the Court of protection process across the five CCGs to ensure that appropriate governance processes are in place	Oct 15	JW
Work with Safeguarding Adult Boards to review serious cases in line with the Care Act 2014 with learning events for CCG and provider staff	Dec 15	JW
Consult with adult leads with a view to strengthening the role by increasing capacity to deliver the requirements of the Care Act 2014.	Sept 15	JW
Obtain approval for the CCG Adult Safeguarding Policy at September Governing Body meetings, and implement any outstanding requirements thereafter	Sept 15	JW
Develop safeguarding supervision strategy across the health economy	Oct 15	JW
CCGs to increase levels of compliance with safeguarding and prevent training	Oct 15	MDs

Assurances: (How do we know if the things we are doing are having an impact?)

- CCG Quality & Safety Committee minutes showing quarterly Safeguarding Adults reports.
- Quarterly agenda item for CQGs with monthly monitoring of training for non-compliant trusts
- Pressure Ulcer working group to improve reporting and causes of pressure ulcers
- MCA project progressing to engage Care Homes, Trusts and GPs in training
- GP training strategy completed and being shared with CCGs.

Gaps in assurance: (What additional assurances should we seek?)

- Ascertain how compliant the CCGs are with the DOLs Supreme Court ruling @Cheshire West'
- Further assurances required regarding patients who move across CCG boundaries, or long distances, to ensure that they are appropriately managed.
- Gaps in adult safeguarding training for GPs being identified via CQC visits – GPs are accountable; Health Education England should be providing resources for the training
- CCGs safeguarding and 'Prevent' training compliance

Current performance: (With these actions taken, how serious is the problem?)

Some Trusts are not maintaining compliance with training requirements for safeguarding, MCA and 'Prevent'
Training for GPs needs to be increased but requires agreement for funding in all the CCGs.

Additional Comments

s75 arrangements with Westminster, Hammersmith and Fulham, Kensington and Chelsea Councils have been reviewed but there is a need to clarify the extent and impact of financial cuts.

3

Objective 2: Securing quality healthcare services and improved outcomes for the people we commission services for		Director lead: Managing Directors, West London and Hounslow CCGs																																								
Risk 4- Chelsea and Westminster Hospital NHS Foundation Trust: Risk that the acquisition of West Middlesex Hospital does not realise the expected benefits for patients.		Date last reviewed: September 2015																																								
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<p>Controls: <i>(What are we currently doing about the risk?)</i></p> <ul style="list-style-type: none"> 100 day plan post acquisition Transition Board has continued as a Benefits Realisation Group, post transition, to ensure merger benefits are realised Transition Board overseeing acquisition Contract review meetings and Clinical Quality Group meetings West London and Hounslow CCGs performance management regimes of Trust Performance & Contracting Executive responsible for oversight of contract, assessing risks and reporting to Finance & Performance, and Quality meetings Transaction Agreement in place 		<p>Mitigating actions: <i>(What more should we do?:)</i></p> <table border="1"> <tbody> <tr> <td>West London and Hounslow CCGs to develop joint working arrangements including Terms of Reference for commissioning arrangements</td> <td>Sept 15</td> <td>MDs</td> </tr> <tr> <td>Continue to work with the existing contract, quality and performance structure</td> <td>On going</td> <td></td> </tr> <tr> <td>Tracking of referral to treatment (RTT) in key areas to improve pathway management</td> <td>Oct 15</td> <td></td> </tr> <tr> <td>Clarity on CCG representation on the FT Board of Governors</td> <td>Sept 15</td> <td>DoC</td> </tr> <tr> <td>Cross-reference to the mitigating actions for Risk 3: Safeguarding Adults, including work with providers to ensure that their safeguarding arrangements are in line with the Care Act 2014.</td> <td>Sept 15</td> <td>JW</td> </tr> </tbody> </table>		West London and Hounslow CCGs to develop joint working arrangements including Terms of Reference for commissioning arrangements	Sept 15	MDs	Continue to work with the existing contract, quality and performance structure	On going		Tracking of referral to treatment (RTT) in key areas to improve pathway management	Oct 15		Clarity on CCG representation on the FT Board of Governors	Sept 15	DoC	Cross-reference to the mitigating actions for Risk 3: Safeguarding Adults, including work with providers to ensure that their safeguarding arrangements are in line with the Care Act 2014.	Sept 15	JW																								
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<p>Assurances: <i>(How do we know if the things we are doing are having an impact?)</i></p> <ul style="list-style-type: none"> Quality, Patient Safety & Risk and Finance & Performance Committees report directly to Governing Bodies Reports to Clinical Quality Group Additional meetings being held with Clinical Quality Group/ Quality Committee to ensure quality indicators are being met Initial transition to new organisation has progressed smoothly with new CEO in place and visibility of leadership across the entirety of the organisation 		<p>Gaps in assurance: <i>(What additional assurances should we seek?)</i></p> <ul style="list-style-type: none"> Assurance that existent good practice in both former organisations is shared and assimilated. Evidence to demonstrate progress to improve serious incident reporting/ management to align with national standards required Assurances gained at Clinical Quality Group didn't align with CQC report. We need to tighten clinical engagement with the trust. Visibility of leadership across the entirety of the organisation 																																								
<p>Current performance: <i>(With these actions taken, how serious is the problem?)</i></p> <ul style="list-style-type: none"> Serious incident reporting at C&W is a cause for concern - different profile from other acute Trusts in NW London. Work is underway to address this issue. C&W is working to increase clinical engagement with commissioners 		<p>Additional Comments</p> <ul style="list-style-type: none"> Should non-performance in serious incident reporting/ management continue, a Board to Board session may be considered 																																								
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Objective 2: Securing quality healthcare services and improved outcomes for the people we commission services for		Director lead: Managing Director, Hammersmith & Fulham CCG																																								
Risk 5 – Imperial College Healthcare NHS Trust: Risk that the Trust does not deliver quality and performance requirements and strategic change to the require timescales, particularly in relation to: Accident & Emergency performance; Non-elective pathway changes; Referral to Treatment pathway – 18 week wait; Outpatients transformation		Date last reviewed: September 2015																																								
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<p>Controls: <i>(What are we currently doing about the risk?)</i></p> <ul style="list-style-type: none"> Imperial executive team meet CWHHE Chairs and Chief Officer every 6 weeks to discuss and agree strategy and explicit arrangements for CCGs to be involved in strategy development and Performance issues. Integrated clinically-led team of CCG lead commissioners across five + NWL CCGs supported by a dedicated contract team and a monthly forum with Associate CCGs in place Integrated approach, with joined up working with NHS England specialised commissioning team, TDA and NHS England assurance teams Cascade of information across CCG Governing Bodies and sub-committees and by CCG links to locality and practice teams Range of approaches in place including clinical assurance testing, audits and walk the pathway visits to areas of strategic focus 		<p>Mitigating actions: <i>(What more should we do?):</i></p> <table border="1"> <tr> <td>Formal contract action through use of the full range of contract levers if provider performance falls below expected standards</td> <td>Through 15/16</td> <td>CCG MD</td> </tr> <tr> <td>Connect up performance review mechanisms across Imperial single organisational approach, working jointly with NHS England specialised commissioning and TDA, working in alignment with system-wide approaches led by System Resilience Groups and NHSE</td> <td>Through 15/16</td> <td>CCG MD & CP</td> </tr> <tr> <td>Connect up in and out of hospital pathway commissioning, working with referrers as well as Imperial team</td> <td>Through 15/16</td> <td>CWHHE MDs & CP</td> </tr> </table>		Formal contract action through use of the full range of contract levers if provider performance falls below expected standards	Through 15/16	CCG MD	Connect up performance review mechanisms across Imperial single organisational approach, working jointly with NHS England specialised commissioning and TDA, working in alignment with system-wide approaches led by System Resilience Groups and NHSE	Through 15/16	CCG MD & CP	Connect up in and out of hospital pathway commissioning, working with referrers as well as Imperial team	Through 15/16	CWHHE MDs & CP																														
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<p>Assurances: <i>(How do we know if the things we are doing are having an impact?)</i></p> <ul style="list-style-type: none"> Assurance from tests including clinical review, audits and walk the pathway visits to areas of strategic focus Contract review briefs and performance reporting feeding into Quality Committee minutes and Finance and Performance Committee minutes to CCG Governing Bodies Imperial's outline business case demonstrated alignment with Shaping a Healthier Future strategy Joint monitoring with TDA of Imperial's progress against its action plan in response to CQC reports Imperial's level of engagement of CCG clinical leads and referrers in its transformational programme, particularly outpatients, and the use of Community Independence Services to reduce NEL admission 		<p>Gaps in assurance: <i>(What additional assurances should we seek?)</i></p> <ul style="list-style-type: none"> That Information systems can provide complete and up-to-date information on which to base commissioning decisions and monitor quality performance Lack of assurance that providers can manage demand Infection control systems are operating effectively 																																								
<p>Current performance: <i>(With these actions taken, how serious is the problem?)</i></p> <ul style="list-style-type: none"> Particular focus needed for challenged specialties to deliver the 18 week RTT pathway - breast / plastics; ENT – adults and children; general surgery; ophthalmology; outpatients; orthopaedics; vascular; and urology. Outpatients transformation programme must tackle underlying system and process for booking and following up patients to facilitate better use of capacity, better patient experience and smoother working with referrers Substantial efforts to improve the emergency pathway, use of A&E and wider emergency services including UCCs as well as ambulatory emergency care and community independence services must be developed and sustained. 		<p>Additional Comments</p> <ul style="list-style-type: none"> CCGs to align with Imperial and TDA on Foundation Trust application Delivery of Trust transformational programme must show an impact Urgent Care Centre at St Mary's is not operating optimally – need to have a clear plan for improvement. Need a plan for ambulatory care. 	5																																							

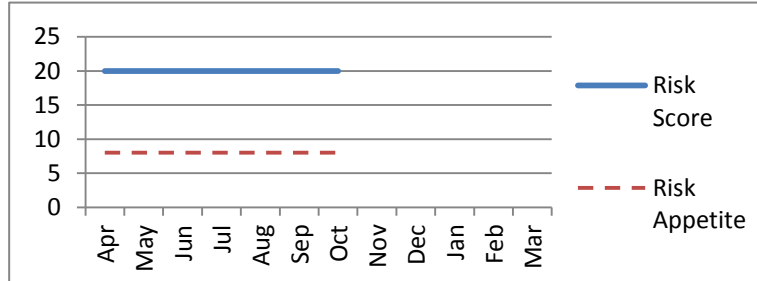
Objective 2: Securing quality healthcare services and improved outcomes for the people we commission services for

Director lead: Managing Director, Ealing CCG

Risk 6 – London North West NHS Trust: Risk that the Trust (incorporating Ealing Hospital) does not deliver quality and performance requirements to the required timescales, particularly in relation to: Community Services; Cancer; Staffing levels and Trust finances

Date last reviewed: September 2015

Risk Rating
(likelihood x consequence):
Initial: 5 x 4 = 20
Current: 5 x 4 = 20
Appetite: 2 x 4 = 8



Rationale for current score:

There are concerns regarding the sustainability of the Trust and the quality of care provided. There are currently challenges in relation to the Paediatric transfer. The risk is compounded by the negative financial position of the Trust.

Rationale for risk appetite:

Contract management and other processes aim to mitigate the risk to an acceptable level

Controls: (What are we currently doing about the risk?)

- PCE meetings for the acute and community contracts
- Clinical Quality Group meetings for the acute and community contracts
- Quality measures agreed as part of the 2015/2016 contract
- Board to Board and PCE meetings.
- Associates meetings with other commissioners

Mitigating actions: (What more should we do?):

Continued actions through CQG and PCE meetings	Ongoing	MD
Working with the Trust, BHH and the TDA to understand the Trust's Cost Improvement Plans and capital development plans	Ongoing	D of S&T
Implementation Business Case to be submitted to NHSE relating to Shaping a Healthier Future – this should help address underlying financial position in the longer time.	Mar 16	D of S&T

Assurances: (How do we know if the things we are doing are having an impact?)

- Quality and Performance report
- Monitoring performance and quality via contract meetings and the Clinical Quality Group meetings.
- Joint action plan to improve access to cancer services presented to the performance committee
- Minutes of the special quality committee meeting in July/August looking at quality.

Gaps in assurance: (What additional assurances should we seek?)

- We need a comprehensive plan for addressing identified quality issues
- Need to clarify and coordinate commissioning arrangements with BHH to ensure Ealing CCG sufficiently influences the commissioning of LNW Trust.
- A plan for recruiting health visiting staff in the ICO is required.
- CQC not doing an inspection of Ealing Hospital as they did one of the new trust recently. How do we receive an assurance from the CQC specifically about Ealing Hospital?
- Require assurances that there is adequate management in place to deliver the Ealing community services review findings.
- There is a need for a Financial Recovery Plan for LNW NHS Trust

Current performance: (With these actions taken, how serious is the problem?)

- RTT performance is below contracted levels.
- Ealing ICO running at a high vacancy rate.
- Trust finances remain a cause for concern.

Additional Comments

Need to discuss plans with Brent and Harrow CCGs along with the Trust Development Agency, to align approaches.

6

Objective 2: Securing quality healthcare services and improved outcomes for the people we commission services for		Director lead: Managing Director, Central London CCG																																								
Risk 7 - Central London Community Healthcare NHS Trust: Risk that the organisation is not delivering strategic change and operational performance, with a focus on safe services, during the procurements of care home services, and transformation of community nursing		Date last reviewed: September 2015																																								
<p>Risk Rating (likelihood x consequence): Initial: 4 x 5 = 20 Current: 4 x 5 = 20 Appetite: 2 x 4 = 8</p>	<table border="1"> <caption>Risk Rating Data</caption> <thead> <tr> <th>Month</th> <th>Risk Score</th> <th>Risk Appetite</th> </tr> </thead> <tbody> <tr><td>Apr</td><td>20</td><td>8</td></tr> <tr><td>May</td><td>20</td><td>8</td></tr> <tr><td>Jun</td><td>20</td><td>8</td></tr> <tr><td>Jul</td><td>20</td><td>8</td></tr> <tr><td>Aug</td><td>20</td><td>8</td></tr> <tr><td>Sep</td><td>20</td><td>8</td></tr> <tr><td>Oct</td><td>20</td><td>8</td></tr> <tr><td>Nov</td><td>20</td><td>8</td></tr> <tr><td>Dec</td><td>20</td><td>8</td></tr> <tr><td>Jan</td><td>20</td><td>8</td></tr> <tr><td>Feb</td><td>20</td><td>8</td></tr> <tr><td>Mar</td><td>20</td><td>8</td></tr> </tbody> </table>	Month	Risk Score	Risk Appetite	Apr	20	8	May	20	8	Jun	20	8	Jul	20	8	Aug	20	8	Sep	20	8	Oct	20	8	Nov	20	8	Dec	20	8	Jan	20	8	Feb	20	8	Mar	20	8	<p>Rationale for current score: Delivery of Out of Hospital strategy is dependent on the community nursing and whole systems integrated care models being implemented.</p> <p>Rationale for risk appetite: Successful design and implementation will potentially deliver improvements to patient experience and outcomes.</p>	
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<p>Controls: <i>(What are we currently doing about the risk?)</i></p> <ul style="list-style-type: none"> A programme to oversee delivery of the improvement plan is in place which reports to the CLCH contract performance committee. CLCH have agreed with the principle that we pass day to day management of community nurses to GP localities. 		<p>Mitigating actions: <i>(What more should we do?:)</i></p> <table border="1"> <tr> <td>Service delivery improvement plan being enacted</td> <td>On-going</td> <td>MB</td> </tr> <tr> <td>Formal contract action through use of the full range of contract levers if provider performance falls below expected standards</td> <td>Throughout 15/16</td> <td>MB</td> </tr> <tr> <td>Raise at the next contracting meetings the issue of data collection and reporting.</td> <td>Sept 15</td> <td>MB</td> </tr> </table>		Service delivery improvement plan being enacted	On-going	MB	Formal contract action through use of the full range of contract levers if provider performance falls below expected standards	Throughout 15/16	MB	Raise at the next contracting meetings the issue of data collection and reporting.	Sept 15	MB																														
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<p>Assurances: <i>(How do we know if the things we are doing are having an impact?)</i></p> <ul style="list-style-type: none"> Quality and Performance report. Monitoring of the Transition plan Feedback from CCG Chairs, Governing Bodies, members and patients. 		<p>Gaps in assurance: <i>(What additional assurances should we seek?)</i></p> <ul style="list-style-type: none"> Absence of accurate and timely information is hampering effective commissioning and quality monitoring e.g. pressure ulcer reporting We don't have assurances that the new health visiting arrangements will provide the continuity of care and consistent quality of care for our patients. 																																								
<p>Current performance: <i>(With these actions taken, how serious is the problem?)</i></p> <ul style="list-style-type: none"> Serious incident reporting timescales can be improved. Waiting times for services can be improved. Pressure ulcer management and venous thromboembolism performance/reporting could be improved. Based on what we understand to be poor quality data, Trust is required to report district nursing activity Podiatry for Central London CCG is being scrutinised for its access/waiting times performance 		<p>Additional Comments</p> <p>There are risks concerning the 1) vacancy rates 2) the Trust's failure to provide workforce data and overall workforce development 3) an increased risk due to the combination of pool and agency nurses in the urgent care centres.</p> <p>Risk definition to be reviewed at the end of August to reflect transfer of nursing homes to Sanctuary.</p>	7																																							

Objective 2: Securing quality healthcare services and improved outcomes for the people we commission services for		Director lead: Managing Director, Ealing CCG																																								
Risk 8 - West London Mental Health NHS Trust: Risk that the organisation is not well positioned to deliver strategic change and operational performance.		Date last reviewed: September 2015																																								
Risk Rating (likelihood x consequence): Initial: 4 x 4 = 16 Current: 3 x 4 = 12 Appetite: 2 x 4 = 8	<table border="1"> <caption>Risk Score and Appetite Data</caption> <thead> <tr> <th>Month</th> <th>Risk Score</th> <th>Risk Appetite</th> </tr> </thead> <tbody> <tr><td>Apr</td><td>16</td><td>8</td></tr> <tr><td>May</td><td>12</td><td>8</td></tr> <tr><td>Jun</td><td>12</td><td>8</td></tr> <tr><td>Jul</td><td>12</td><td>8</td></tr> <tr><td>Aug</td><td>12</td><td>8</td></tr> <tr><td>Sep</td><td>12</td><td>8</td></tr> <tr><td>Oct</td><td>12</td><td>8</td></tr> <tr><td>Nov</td><td>12</td><td>8</td></tr> <tr><td>Dec</td><td>12</td><td>8</td></tr> <tr><td>Jan</td><td>12</td><td>8</td></tr> <tr><td>Feb</td><td>12</td><td>8</td></tr> <tr><td>Mar</td><td>12</td><td>8</td></tr> </tbody> </table>	Month	Risk Score	Risk Appetite	Apr	16	8	May	12	8	Jun	12	8	Jul	12	8	Aug	12	8	Sep	12	8	Oct	12	8	Nov	12	8	Dec	12	8	Jan	12	8	Feb	12	8	Mar	12	8	Rationale for current score: West London Mental Health Trust has an ambitious transformation programme in place and has a significant role to play in the successful delivery of the out of hospital strategy. The current risk score will be reviewed once the outcome of the CQC review is known.	Rationale for risk appetite: Measures are being put in place aiming to reduce the likelihood of problems arising with service levels.
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Controls: <i>(What are we currently doing about the risk?)</i> <ul style="list-style-type: none"> Transformation Board is in place and co-chaired by a Hounslow GP Governing Body Member and West London Mental Health Trust Medical Director. Board has agreed priorities for 2015 to 2017 Working groups in place to support transformation priorities and delivery managers work being prioritised to support. CQG and PCE operating on a monthly basis with attendance from all three commissioning CCGs and WLMHT. Line Minded strategy being developed across NWL. Regular commissioner discussions 		Mitigating actions: <i>(What more should we do?)</i> <table border="1"> <tr> <td>Continuing to monitor performance and quality through contract meetings and clinical quality group meetings.</td> <td>On going</td> <td>TS</td> </tr> <tr> <td>Ensure commissioning ownership of the Trust transformation plans</td> <td>On going</td> <td>TS/MW/KS</td> </tr> </table>		Continuing to monitor performance and quality through contract meetings and clinical quality group meetings.	On going	TS	Ensure commissioning ownership of the Trust transformation plans	On going	TS/MW/KS																																	
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Ensure commissioning ownership of the Trust transformation plans	On going	TS/MW/KS																																								
Assurances: <i>(How do we know if the things we are doing are having an impact?)</i> <ul style="list-style-type: none"> Updates and mental health issues presented to governing bodies by the lead commissioner. Mental health Trust engaging with local Health and Wellbeing Boards 		Gaps in assurance: <i>(What additional assurances should we seek?)</i> <ul style="list-style-type: none"> Structured and systematic reporting process not in place. Some concerns about the ability of WLMHT to deliver improvement actions. We need to see suicide rates benchmarking data to enable us to assess relative priority areas to address. Require further assurances that sufficient patient engagement has taken place about any changes to services. An Estates Strategy that meets commissioner requirements Slow implementation of recruitment as a result of parity of esteem investments 																																								
Current performance: <i>(With these actions taken, how serious is the problem?)</i> Performance falling below expected levels in some areas.		Additional Comments <ul style="list-style-type: none"> Shifting Settings of Care discharge - there is low trajectory in terms of the overall target for discharges made into enhanced primary care. H&F CCG have particular concerns that the needs of local residents are not sufficiently elevated. This risk is higher in H&F. 	8																																							

Objective 2: Securing quality healthcare services and improved outcomes for the people we commission services for		Director lead: Managing Director, West London CCG																																								
Risk 9 - Central & North West London NHS Foundation Trust: Risk that the Trust does not deliver quality and performance requirements and strategic change to the required timescales, particularly in relation to: <ul style="list-style-type: none"> Staffing levels Financial position Service transformation and capacity to deliver change Bed capacity – Care Quality Commission Report 		Date last reviewed: September 2015																																								
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Controls: <i>(What are we currently doing about the risk?)</i> <ul style="list-style-type: none"> Contract review meetings and Clinical Quality Group meetings WLCCG: associate commissioner, Senior Lead for mental health appointed and gives regular input to Quality, Patient Safety & Risk Committee Updates on action plans and accelerated service improvement plans to Clinical Quality Group Clinical Quality Group focussing on how Care Quality Commission findings will be addressed 		Rationale for risk appetite: Contract management and other processes are in place and aim to reduce the likelihood of issues occurring. However, risks can never be completely eliminated, as reflected in the risk appetite rating applied.																																								
Assurances: <i>(How do we know if the things we are doing are having an impact?)</i> <ul style="list-style-type: none"> Quality, Patient Safety & Risk and Finance & Performance Committees report directly to Governing Bodies Reports to Clinical Quality Group 		Mitigating actions: <i>(What more should we do?)</i> <table border="1"> <tbody> <tr> <td>Ensure commissioning ownership of the Trust's financial and transformation plans</td> <td>On going</td> <td>LP</td> </tr> <tr> <td>Continue to work with the existing contract, quality and performance structure</td> <td>On going</td> <td></td> </tr> <tr> <td>Review communication flow between CQG/CCG Quality meeting and implement improved communications</td> <td>Oct 15</td> <td>LP/JW</td> </tr> <tr> <td>'Like-minded' strategy will drive transformation of services for future models of care</td> <td></td> <td>HD</td> </tr> </tbody> </table>		Ensure commissioning ownership of the Trust's financial and transformation plans	On going	LP	Continue to work with the existing contract, quality and performance structure	On going		Review communication flow between CQG/CCG Quality meeting and implement improved communications	Oct 15	LP/JW	'Like-minded' strategy will drive transformation of services for future models of care		HD																											
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'Like-minded' strategy will drive transformation of services for future models of care		HD																																								
Current performance: <i>(With these actions taken, how serious is the problem?)</i> <ul style="list-style-type: none"> Given the expansion to provide services at Milton Keynes and the current two enforcement notices, concerns remain. 		Gaps in assurance: <i>(What additional assurances should we seek?)</i> <ul style="list-style-type: none"> More input to North West London Mental Health Transformation Programme Board required. We need suicide rates benchmarking data to enable assessment of relative priority areas. Address variability in national IAPT targets Contract signed 																																								
		Additional Comments : The Carnall Farrar review of mental health services across North West London will help us to address this risk																																								
			9																																							

Objective 2: Securing quality healthcare services and improved outcomes for the people we commission services for		Director lead: Andrew Burgess, Director of Contracts, Procurement and Performance																																								
Risk 10 - London Ambulance Service NHS Trust: Risk that the workforce is not in place to deliver the high quality, value for money service required, leading to delays in attending patients and risk of serious patient harm.		Date last reviewed: September 2015																																								
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<p>Controls: (What are we currently doing about the risk?)</p> <ul style="list-style-type: none"> Brent CCG is the lead commissioner acting on behalf of London CCGs Additional funding invested in LAS for 15/16 to help address resource gaps – funding tied closely to successful delivery of the Performance improvement plan. Provider has a recruitment plan in place which includes recruitment of paramedics from Australia – majority of staff to be recruited in Jan/Feb 2016 Recruiting EACs Appointing clinical team leaders to help change organisational culture 		<p>Mitigating actions: (What more should we do?):</p> <table border="1"> <tr> <td>Monitoring performance each quarter with actions taken as appropriate via contract meetings.</td> <td>DoCP&P</td> <td>Sept 2015</td> </tr> <tr> <td>Exception reports being reviewed. New versions to be ready by Sept 2015</td> <td>DofCP&P</td> <td>Sept 2015</td> </tr> </table> <p>[Governance Team Comment: Are there further mitigation actions needed to reduce the risk rating to the risk appetite?]</p>		Monitoring performance each quarter with actions taken as appropriate via contract meetings.	DoCP&P	Sept 2015	Exception reports being reviewed. New versions to be ready by Sept 2015	DofCP&P	Sept 2015																																	
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Exception reports being reviewed. New versions to be ready by Sept 2015	DofCP&P	Sept 2015																																								
<p>Assurances: (How do we know if the things we are doing are having an impact?)</p> <ul style="list-style-type: none"> Weekly exception report reviewed by contracting team, including staff levels and sickness (structure of report being reviewed by TDA and NHSE to ensure better alignment to the Performance Improvement Plan) Monthly contracts and performance meeting with commissioning leads Monthly CQG meeting to which GPs/clinical leads are invited 		<p>Gaps in assurance: (What additional assurances should we seek?)</p> <ul style="list-style-type: none"> Exception reports not adequately aligned to provide assurance that the performance improvement plan is delivering 																																								
<p>Current performance: (With these actions taken, how serious is the problem?)</p> <ul style="list-style-type: none"> Achieving ambulance emergency performance is a quite delicate balance between activity, available resource and effective utilisation of this resource. LAS are working on increasing the available resource and improving resource utilisation. Demand (activity) levels are currently below forecast. LAS performance is variable and hovering around the current agreed performance trajectory. A major improvement in performance is expected in August, and is reflected in the agreed trajectory. This is expected to be a taxing time for LAS. 		<p>Additional Comments :</p>																																								
			10																																							

Objective 2: Securing quality healthcare services and improved outcomes for the people we commission services for		Director lead: Director of Quality & Patient Safety																																							
Risk 11 – Care homes and care packages: Risk that quality and financial challenges in care providers (such as care homes, supported housing, domiciliary care or other care packages commissioned by CCGs) leads to patient harm and/or safeguarding concerns, as well as to pressure on Accident & Emergency and non-elective activity.		Date last reviewed: September 2015																																							
<p>Risk Rating (likelihood x consequence): Initial: 4 x 5 = 20 Current: 4 x 5 = 20 Appetite: 2 x 5 = 10</p> <table border="1"> <caption>Risk Rating Data</caption> <thead> <tr> <th>Month</th> <th>Risk Score</th> <th>Risk Appetite</th> </tr> </thead> <tbody> <tr><td>Apr</td><td>20</td><td>10</td></tr> <tr><td>May</td><td>20</td><td>10</td></tr> <tr><td>Jun</td><td>20</td><td>10</td></tr> <tr><td>Jul</td><td>20</td><td>10</td></tr> <tr><td>Aug</td><td>20</td><td>10</td></tr> <tr><td>Sep</td><td>20</td><td>10</td></tr> <tr><td>Oct</td><td>20</td><td>10</td></tr> <tr><td>Nov</td><td>20</td><td>10</td></tr> <tr><td>Dec</td><td>20</td><td>10</td></tr> <tr><td>Jan</td><td>20</td><td>10</td></tr> <tr><td>Feb</td><td>20</td><td>10</td></tr> <tr><td>Mar</td><td>20</td><td>10</td></tr> </tbody> </table>	Month	Risk Score	Risk Appetite	Apr	20	10	May	20	10	Jun	20	10	Jul	20	10	Aug	20	10	Sep	20	10	Oct	20	10	Nov	20	10	Dec	20	10	Jan	20	10	Feb	20	10	Mar	20	10	<p>Rationale for current score: Care Homes/ care package placements are a high risk area for the CCGs due to demands on the care system in response to the out-of-hospital strategy. The commissioning of this provision is considered jointly with the Local Authorities and continues to be a challenge in relation to sufficient funding to ensure good quality care provided by appropriately trained staff in the right settings. The CQC has revised its inspection regime which is placing additional pressure on commissioners for ensuring the safety and welfare for the patients they are responsible for placing.</p> <p>Rationale for risk appetite: This reflects the unpredictability of the failure of the care home/ domiciliary care provider system.</p>	
Month	Risk Score	Risk Appetite																																							
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<p>Controls: <i>(What are we currently doing about the risk?)</i></p> <ul style="list-style-type: none"> Cooperation with LA provider concerns process Joint working by safeguarding team and continuing health care teams/ commissioners to monitor the quality of care in homes Working with care homes for the hydration project Engagement of Care Homes in the MCA project being led by Bucks University Working with the Local Authorities and CQC to predict and identify risks in the system Safeguarding training for CCG staff 	<p>Mitigating actions: <i>(What more should we do?):</i></p> <table border="1"> <tbody> <tr> <td>Strengthen the quality assurance and contract monitoring of domiciliary and care homes we commission services from</td> <td>JW/MDs</td> <td>Oct 15</td> </tr> <tr> <td>Re launch Quality Assurance Group for CHC</td> <td>JW</td> <td>Sept 15</td> </tr> <tr> <td>Evaluate the effectiveness of the pathway for NHS funded care</td> <td>JW</td> <td>Dec 15</td> </tr> <tr> <td>Cooperate with Safeguarding Adult Boards to implement the learning from Safeguarding Adult Reviews in relation to the care system</td> <td>JW</td> <td>Dec 15</td> </tr> <tr> <td>Consult with adult leads with a view to strengthening the role by increasing capacity to deliver the requirements of the Care Act 2014.</td> <td>JW</td> <td>Sept 15</td> </tr> <tr> <td>Ensure placements are made primarily on the basis of clinical need and safety</td> <td>JW/SJ/JC</td> <td>Dec 15</td> </tr> <tr> <td>Review KPIs and performance of CHC and FNC</td> <td>JW/SJ/JC</td> <td>Dec 15</td> </tr> <tr> <td>Review the service specifications for CHC teams to ensure that they encompass the systems and processes necessary to discharge the CCGs statutory requirements</td> <td>JW</td> <td>Oct 15</td> </tr> </tbody> </table>		Strengthen the quality assurance and contract monitoring of domiciliary and care homes we commission services from	JW/MDs	Oct 15	Re launch Quality Assurance Group for CHC	JW	Sept 15	Evaluate the effectiveness of the pathway for NHS funded care	JW	Dec 15	Cooperate with Safeguarding Adult Boards to implement the learning from Safeguarding Adult Reviews in relation to the care system	JW	Dec 15	Consult with adult leads with a view to strengthening the role by increasing capacity to deliver the requirements of the Care Act 2014.	JW	Sept 15	Ensure placements are made primarily on the basis of clinical need and safety	JW/SJ/JC	Dec 15	Review KPIs and performance of CHC and FNC	JW/SJ/JC	Dec 15	Review the service specifications for CHC teams to ensure that they encompass the systems and processes necessary to discharge the CCGs statutory requirements	JW	Oct 15															
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<p>Assurances: <i>(How do we know if the things we are doing are having an impact?)</i></p> <ul style="list-style-type: none"> Provider concerns reports to part 2 of QPSRs and Governing Bodies Director to Director meetings for failing providers in conjunction with the LA 	<p>Gaps in assurance: <i>(What additional assurances should we seek?)</i></p> <p>Assurance of appropriate medical cover in Care Homes, as well as wider health services in working with care providers</p> <ul style="list-style-type: none"> That CHC teams have the capacity to meet the increasing OOH demands Effectiveness that the pathway for NHS funded care is working to provide good quality and safe care for patients CCGs role in DOLs (see safeguarding adults risk) 																																								
<p>Current performance: <i>(With these actions taken, how serious is the problem?)</i></p> <p>The quality of provision delivered by care homes /domiciliary care continues to give cause for concern.</p>	Additional Comments :	11																																							

Objective 2: Securing quality healthcare services and improved outcomes for the people we commission services for		Director lead: Managing Directors																									
Risk 12 – Federations: Risk that Primary care is unable to deliver increased activity due to organisational and workforce issues (includes implications of working at scale and establishing GP federations).		Date last reviewed: September 2015																									
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<p>Controls: <i>(What are we currently doing about the risk?)</i></p> <ul style="list-style-type: none"> • Tri-partite agreements with commissioners, Federations and primary care providers outline expectations regarding delivery of OOH contracts • Shared contracts team to pool resources and enable CCG teams to focus on local providers • Monthly contracting meetings • Transformation funding agreed for Federation organisational development • Workforce strategy and plan being developed by Federation • Bids being made to HENWL for workforce development monies as they become available • Nursing workforce development plan being prepared 		<p>Mitigating actions: <i>(What more should we do?)</i></p> <table border="1"> <tbody> <tr> <td>Funding from Health Education North West London to support training and development for new ways of working</td> <td>Dec 15</td> <td>MDs</td> </tr> <tr> <td>Establish Clinical Quality and Performance Group/s for new providers</td> <td>Oct 15</td> <td>JW/MDs</td> </tr> <tr> <td>Indicators for monthly integrated performance and quality reports to be developed</td> <td>Sept 15</td> <td>AB</td> </tr> <tr> <td>Continue discussion with Local Authority regarding development of joint approach to recruitment and retention of health and social care staff locally</td> <td></td> <td></td> </tr> <tr> <td>Increasing quality capacity at CCG level</td> <td>Dec 15</td> <td>JW</td> </tr> </tbody> </table>		Funding from Health Education North West London to support training and development for new ways of working	Dec 15	MDs	Establish Clinical Quality and Performance Group/s for new providers	Oct 15	JW/MDs	Indicators for monthly integrated performance and quality reports to be developed	Sept 15	AB	Continue discussion with Local Authority regarding development of joint approach to recruitment and retention of health and social care staff locally			Increasing quality capacity at CCG level	Dec 15	JW									
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<p>Assurances: <i>(How do we know if the things we are doing are having an impact?)</i></p> <ul style="list-style-type: none"> • Feedback from patients and practices • Monthly monitoring of OOH contracts by F&P Committees 		<p>Gaps in assurance: <i>(What additional assurances should we seek?)</i></p> <ul style="list-style-type: none"> • Spring 2016: out of hospital service specification final review • Organisational Development plan for each Federation 																									
<p>Current performance: <i>(With these actions taken, how serious is the problem?)</i></p>		<p>Additional Comments : Local Medical Committees input essential to the success of Federations.</p>	12																								

Objective 3: Enhancing the organisation's culture – developing people, processes and systems to help deliver high quality commissioning		Director lead: Chief Officer													
Risk 13 – Primary care co-commissioning: Risk that the structures and behaviours established to jointly co-commission primary care with NHS England: <ul style="list-style-type: none"> do not enable us to commission the change required to deliver our strategy; adversely affect relationships with member practices, leading to difficulties in, for example, PMS contract review create significant conflicts of interest; and lack capacity to deliver the corporate aspects of co-commissioning, with a potential impact on the quality of commissioning arising from (for example) insufficient senior oversight, leading to challenges in delivering the change to services in our plans. 		Date last reviewed: September 2015													
Risk Rating (likelihood x consequence): (likelihood x consequence): Initial: 4 x 4 = 16 Current: 4 x 4 = 16 Appetite: 3 x 3 = 9	<p>The chart displays Risk Score (solid blue line) and Risk Appetite (dashed red line) over time from April to February. The Risk Score is constant at 16, which is above the Risk Appetite of 9.</p>	Rationale for current score: <ul style="list-style-type: none"> Co-commissioning is a new form of commissioning and NHSE is still to define several aspects of its operation. There is a complex matrix of relationships for the CCGs to navigate across co-commissioning, including with NHSE, Healthwatch, HWBs, and LMC. Co-commissioning brings the CCGs further into the orbit of decision-making about individual GP practices, with potential damage to relationships if disputes arise. Primary care has risen up the political agenda over the last eighteen months, which is likely to increase external scrutiny of co-commissioning in North West London. Rationale for risk appetite: <ul style="list-style-type: none"> The decision by governing bodies and member practices to enter into co-commissioning demonstrated a basic appetite for the risks arising from a period of significant change in commissioning responsibilities and relationships; and the mitigations set out in this BAF reduce the risk score to a level proportionate to the potential benefits arising from joint co-commissioning. 													
Controls: (What are we currently doing about the risk?) <ul style="list-style-type: none"> Alignment of co-commissioning forward planning with local primary care commissioning intentions, through the relevant project teams and programme executive as well as through close engagement with the CCGs and external stakeholders. The CCGs extensively engaged member practices before the co-commissioning votes in March 2015 through presentations, Q&As, and communication materials. The joint committees send their minutes to governing bodies. Additional commentaries are provided as requested by the CCGs. Any intention to progress to delegation will be communicated to members early and involve engagement based on the move to joint co-commissioning. Ongoing engagement with the LMC through the joint committees and existing regular forums through the CCGs and the strategy and transformation team. The co-commissioning Col addendum and original joint committee TOR were agreed with NHSE and have been approved by all five governing bodies. 		Mitigating actions: (What more should we do?): <table border="1"> <tr> <td>Approval of the joint committee ToRS by CCG GBs</td> <td>Sept 15</td> <td>CP</td> </tr> <tr> <td>Further revisions might be required to respond to issues that arise from the practical functioning of the committees.</td> <td>On going</td> <td>S&T</td> </tr> <tr> <td>Ensure actual and potential declarations of interest are effectively managed.</td> <td>On going</td> <td>Chair</td> </tr> <tr> <td>The London-wide co-commissioning operating model is currently being finalised, which will enable confirmation of its resource and financial implications to deliver the corporate aspects of co-commissioning</td> <td></td> <td>S&T</td> </tr> </table>		Approval of the joint committee ToRS by CCG GBs	Sept 15	CP	Further revisions might be required to respond to issues that arise from the practical functioning of the committees.	On going	S&T	Ensure actual and potential declarations of interest are effectively managed.	On going	Chair	The London-wide co-commissioning operating model is currently being finalised, which will enable confirmation of its resource and financial implications to deliver the corporate aspects of co-commissioning		S&T
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Assurances: (How do we know if the things we are doing are having an impact?) <ul style="list-style-type: none"> The updated joint committee terms of reference have been approved by three CCG governing bodies (Ealing, Hammersmith and Fulham, Hounslow) and will be on the agenda for Central London and West London in September 2015. No additional concerns about conflict of interest management were raised in either of the two sessions of the joint committees in common held so far. 		Gaps in assurance: (What additional assurances should we seek?) <ul style="list-style-type: none"> The internal auditor review of co-commissioning, beginning in September 2015, will provide independent assurance about conflicts of interest. Additionally, the CCG (lay audit chair and chief officer) will need to self-certify adherence to NHSE's governance and conflict of interest guidelines in the autumn of 2015. Agreement of the co-commissioning operating model by the CCGs and NHSE so that resource and financial implications can be finalised. That PMS contract reviews are not put at undue risk as a result of these arrangements 													
Current performance: (With these actions taken, how serious is the problem?) <ul style="list-style-type: none"> The operating model and sub-group structure are scheduled for agreement at the joint committees' September meeting – additional uncertainty and risk exist until this happens. NHSE has continued to take decisions for North West London as the joint committee terms of reference have been approved. This means that further appraisal of performance and risk will be required once the NWL structure has gained experience of making decisions. 		Additional Comments : <ul style="list-style-type: none"> It is important that the operating model is signed off at the September meeting of the joint committees so that the correct decision-making and information flow processes can be implemented. 													

Objective 3: Enhancing the organisation's culture – developing people, processes and systems to help deliver high quality commissioning		Director lead: Managing Directors																									
Risk 14 – Engagement: If we do not engage member practices, the LMC and other partners in the change programmes, we will not be able to realise the intended quality improvements.		Date last reviewed: September 2015																									
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<p>Controls: <i>(What are we currently doing about the risk?)</i></p> <ul style="list-style-type: none"> • Patient Reference Group meeting in place and meeting regularly, feeding in to the Engagement and OD committee • Engagement priorities agreed with Engagement and OD Committee and being incorporated into engagement strategy • Proactive use of CCG Twitter account to provide local information to followers • Primary Care Co-Commissioning establishing ways of working, and will include stakeholder representation • Member meetings are key means of communicating change and securing member feedback to inform our plans • Regular reporting of engagement activities to Governing Body • Regular meetings in place with Healthwatch, with use being made of their networks for communicating information • Regular contact with SOBUS with use being made of their networks for communicating information • Maintaining engagement with Health and Wellbeing Board • Implementing action plan arising from Ipsos MORI 360 stakeholder survey • Maintaining regular communication with GPs via monthly newsletter 		<p>Mitigating actions: <i>(What more should we do?)</i></p> <table border="1"> <tbody> <tr> <td>Identify further opportunities to raise profile of the CCG</td> <td></td> <td></td> </tr> <tr> <td>Ensure actions arising from the annual Ipsos MORI 360 stakeholder survey are targeted and implemented</td> <td>Annual</td> <td>MDs</td> </tr> <tr> <td>Need to ensure good engagement with the primary care co-commissioning agenda</td> <td>Ongoing</td> <td>MDs and chairs</td> </tr> <tr> <td>Undertake a stakeholder mapping process as a prelude to developing a Communication & Engagement Strategy to influence key stakeholders in the implementation of CCG priorities and strategies.</td> <td>Ongoing</td> <td>MD</td> </tr> </tbody> </table>		Identify further opportunities to raise profile of the CCG			Ensure actions arising from the annual Ipsos MORI 360 stakeholder survey are targeted and implemented	Annual	MDs	Need to ensure good engagement with the primary care co-commissioning agenda	Ongoing	MDs and chairs	Undertake a stakeholder mapping process as a prelude to developing a Communication & Engagement Strategy to influence key stakeholders in the implementation of CCG priorities and strategies.	Ongoing	MD												
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<p>Assurances: <i>(How do we know if the things we are doing are having an impact?)</i></p> <ul style="list-style-type: none"> • Health & Wellbeing Boards discuss key issues with senior CCG leaders • Annual Ipsos MORI 360 stakeholder survey shows improvement since previous year 		<p>Gaps in assurance: <i>(What additional assurances should we seek?)</i> None identified</p>																									
<p>Current performance: <i>(With these actions taken, how serious is the problem?)</i></p>		<p>Additional Comments : Successful management of this risk will support the implementation of GP Federations and new ways of working, improve the feedback received from patients and service users.</p>	14																								

Objective 5: Planning, developing and delivering strategies and actions that reduce inequalities and improve health outcomes		Director lead: Director of Compliance																						
Risk 15 – Conflicts of interest: Not managing conflicts of interest adequately leaves us open to challenge and reputational damage.		Date last reviewed: September 2015																						
<p>Risk Rating (likelihood x consequence): Initial: 5 x 3 = 15 Current: 5 x 3 = 15 Appetite: 4 x 3 = 12</p>	<p>The graph displays two metrics over a 12-month period from April to March. The Y-axis represents the score, ranging from 0 to 25 in increments of 5. The X-axis lists the months. A solid blue line represents the 'Risk Score', which remains constant at 15 throughout the period. A dashed red line represents the 'Risk Appetite', which remains constant at 12 throughout the period.</p>	<p>Rationale for current score: Conflicts of interest are certain to arise, given the CCGs' commissioning functions, coupled with its constituted membership involved in decision making. The current score is a view of the efficacy of current controls to manage actual and potential conflicts of interest to minimise occurrence and impact.</p> <p>Rationale for risk appetite: By putting in place controls and reinforcing acceptable practices, we can minimise the likelihood of the risk occurring; however, we cannot eliminate this risk.</p>																						
<p>Controls: <i>(What are we currently doing about the risk?)</i></p> <ul style="list-style-type: none"> Each CCG has a constitution in place which encompasses standards of business conduct and management of conflicts of interest. Furthermore, the constitutions were updated, in 2015, to specifically reflect Department of Health guidance on managing conflicts of interest in respect of primary care joint commissioning functions. Conflict of Interest Policy agreed and procedures functioning within each CCG Each CCG maintains a Register of Interest, which is routinely updated. Each Governing Body and Committee meeting requires members to declare any interests, at the outset. Prime Financial Policies, Scheme of Reservation and Delegation, Standards of Business Conduct Policy, Anti-Bribery and Anti-Fraud Policies in place Terms of reference for committees specifically address how conflicts of interest should be managed The Primary Care Co-Commissioning Joint Committee membership has been specifically designed to mitigate against conflicts of interest. Investment Committee in place across collaborative to help protect against conflicts of interest 		<p>Mitigating actions: <i>(What more should we do?)</i></p> <table border="1"> <tr> <td>Review the Conflicts of Interest Policy to ensure it reflects latest advice and take to the Audit Committee</td> <td>DoC</td> <td>Oct 2015</td> </tr> <tr> <td>Draft Procurement Policy to be approved and implemented and this should ensure that conflicts of interest are identified early in the procurement process</td> <td>CFO</td> <td>Oct 2015</td> </tr> <tr> <td>Governing Body members and other identified colleagues to be provided with (refresher) conflict of interest training</td> <td>DoC</td> <td>Dec 2015</td> </tr> <tr> <td>Update register of conflicts of interests and the register of gifts and hospitality, take to the audit committee and publish</td> <td>DoC</td> <td>Oct 2015</td> </tr> <tr> <td>Reissue Codes of Conduct for NHS staff</td> <td>DoC</td> <td>Aug 2015</td> </tr> <tr> <td>Reissue a reminder to all staff about compliance with CCG policies</td> <td>DoC</td> <td>Aug 2015</td> </tr> <tr> <td>Respond to NHSE with assurances that we are managing conflicts of interest</td> <td>DoC</td> <td>Aug 2015</td> </tr> </table>		Review the Conflicts of Interest Policy to ensure it reflects latest advice and take to the Audit Committee	DoC	Oct 2015	Draft Procurement Policy to be approved and implemented and this should ensure that conflicts of interest are identified early in the procurement process	CFO	Oct 2015	Governing Body members and other identified colleagues to be provided with (refresher) conflict of interest training	DoC	Dec 2015	Update register of conflicts of interests and the register of gifts and hospitality, take to the audit committee and publish	DoC	Oct 2015	Reissue Codes of Conduct for NHS staff	DoC	Aug 2015	Reissue a reminder to all staff about compliance with CCG policies	DoC	Aug 2015	Respond to NHSE with assurances that we are managing conflicts of interest	DoC	Aug 2015
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<p>Assurances: <i>(How do we know if the things we are doing are having an impact?)</i></p> <ul style="list-style-type: none"> Internal Audit Report (9.14/15 – June 2015) concludes that the Governing Bodies can take reasonable assurance that the controls upon which the organisation relies to manage this risk are suitably designed, consistently applied and effective. Registers of Interest complete and up to date and published on websites 		<p>Gaps in assurance: <i>(What additional assurances should we seek?)</i></p> <ul style="list-style-type: none"> The Investment Committee should have sight of the procurement process followed when making investment decisions and specifically if any conflicts were raised during the process Each CCG should maintain training records in order to ensure that all members of the Governing Body have attended and completed the training. Each CCG to update register of gifts and hospitality and publish 																						
<p>Current performance: <i>(With these actions taken, how serious is the problem?)</i></p>		<p>Additional Comments : Primary care joint commissioning arrangements will be closely monitored to ensure conflicts of interest are effectively managed.</p>	15																					

Objective 5: Planning, developing and delivering strategies and actions that reduce inequalities and improve health outcomes		Director lead: Director of Strategy & Transformation																																								
Risk 16 – Strategic change (workforce) : Risk that we do not have the required resources in place across the system to deliver strategic change including: <ul style="list-style-type: none"> workforce (including Primary Care workforce) to deliver new models of care training and development for future workforce organisational development programmes that challenge the status quo, communicate the change needed, shape the culture and values needed and empower staff finances to fund transitional change IT systems that make good use of technology 		Date last Reviewed: September 2015																																								
Risk Rating (likelihood x consequence): Initial: 4 x 4 = 16 Current: 4 X 4= 16 Appetite: 2 X 4= 8	<table border="1"> <caption>Risk Rating Data</caption> <thead> <tr> <th>Month</th> <th>Risk Score</th> <th>Risk Appetite</th> </tr> </thead> <tbody> <tr><td>Apr</td><td>16</td><td>8</td></tr> <tr><td>May</td><td>16</td><td>8</td></tr> <tr><td>Jun</td><td>16</td><td>8</td></tr> <tr><td>Jul</td><td>16</td><td>8</td></tr> <tr><td>Aug</td><td>16</td><td>8</td></tr> <tr><td>Sep</td><td>16</td><td>8</td></tr> <tr><td>Oct</td><td>16</td><td>8</td></tr> <tr><td>Nov</td><td>16</td><td>8</td></tr> <tr><td>Dec</td><td>16</td><td>8</td></tr> <tr><td>Jan</td><td>16</td><td>8</td></tr> <tr><td>Feb</td><td>16</td><td>8</td></tr> <tr><td>Mar</td><td>16</td><td>8</td></tr> </tbody> </table>	Month	Risk Score	Risk Appetite	Apr	16	8	May	16	8	Jun	16	8	Jul	16	8	Aug	16	8	Sep	16	8	Oct	16	8	Nov	16	8	Dec	16	8	Jan	16	8	Feb	16	8	Mar	16	8	Rationale for current score: This is one of the largest reconfigurations programmes in the country and part way through implementation. Rationale for risk appetite: If resources are not in place to deliver change, it will quickly impact quality and safety of services across NWL.	
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Controls: (What are we currently doing about the risk?) <ul style="list-style-type: none"> Clinical Workforce – a steering group for the development of a NW London wide workforce has been implemented, working with HE NWL. A baseline of all acute, community and primary care workers has been defined and a strategic framework has been developed. The change academy has been established to develop leadership skills for those working to deliver whole systems care. A finance and activity modelling group consisting of all commissioner and provider Finance Directors has been established to ensure a common view for the creation of all business cases for transitional change. 		Mitigating actions: (What more should we do?): <table border="1"> <tr> <td>Continue work with HENWL to ensure required resources are in place and appropriately trained</td> <td>Ongoing</td> <td>D of S&T</td> </tr> <tr> <td>Strategic Workforce Plan to be taken to governing bodies</td> <td>Sep 15</td> <td>D of S&T</td> </tr> </table>		Continue work with HENWL to ensure required resources are in place and appropriately trained	Ongoing	D of S&T	Strategic Workforce Plan to be taken to governing bodies	Sep 15	D of S&T																																	
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Assurances: (How do we know if the things we are doing are having an impact?) Evaluation of change academy workforce planning process through HENWL. Monitoring recruitment and vacancy through the SaHF programmes.		Gaps in assurance: (What additional assurances should we seek?) These will be identified through the internal and external assurance processes and managed through the programme governance structure.																																								
Current performance: (With these actions taken, how serious is the problem?) Focus through recent maternity change has positively impacted on reducing numbers of vacancies. Paediatrics is the next area for reconfiguring systems change but a similar focus will be used for recruitment and retention. There are new ideas being developed in whole systems with appropriate training and job descriptions.		Additional Comments : Need to ensure that strategic plans across a wider area link to plans at CCG level.																																								
			16																																							

Objective 5: Planning, developing and delivering strategies and actions that reduce inequalities and improve health outcomes		Director lead: Director of Strategy & Transformation																																							
Risk 17– Strategic change (organisations): Risk that provider organisations are not able to support implementation of the strategic changes to acute services		Date last reviewed: September 2015																																							
<p>Risk Rating (likelihood x consequence): Initial: 4 x 4 = 16 Current: 3 x 4 = 12 Appetite: 2 x 4 = 8</p>	<table border="1"> <caption>Risk Rating Data</caption> <thead> <tr> <th>Month</th> <th>Risk Score</th> <th>Risk Appetite</th> </tr> </thead> <tbody> <tr><td>Apr</td><td>16</td><td>8</td></tr> <tr><td>May</td><td>12</td><td>8</td></tr> <tr><td>Jun</td><td>12</td><td>8</td></tr> <tr><td>Jul</td><td>12</td><td>8</td></tr> <tr><td>Aug</td><td>12</td><td>8</td></tr> <tr><td>Sep</td><td>12</td><td>8</td></tr> <tr><td>Oct</td><td>12</td><td>8</td></tr> <tr><td>Nov</td><td>12</td><td>8</td></tr> <tr><td>Dec</td><td>12</td><td>8</td></tr> <tr><td>Jan</td><td>12</td><td>8</td></tr> <tr><td>Feb</td><td>12</td><td>8</td></tr> <tr><td>Mar</td><td>12</td><td>8</td></tr> </tbody> </table>	Month	Risk Score	Risk Appetite	Apr	16	8	May	12	8	Jun	12	8	Jul	12	8	Aug	12	8	Sep	12	8	Oct	12	8	Nov	12	8	Dec	12	8	Jan	12	8	Feb	12	8	Mar	12	8	<p>Rationale for current score: This is one of the largest reconfigurations programmes in the country and is only part way through implementation. The risk to implementation is compounded by the risk that if an adverse event happens in a provider organisation, that might not be related to the programme, then there could be a perceived or real attribution of a link leading to negative impact on our reputation and subsequent risk to delivery.</p> <p>Rationale for risk appetite: If these changes are not delivered it will quickly impact quality and safety of services across NWL.</p>
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<p>Controls: <i>(What are we currently doing about the risk?)</i></p> <ul style="list-style-type: none"> Programme Board – representatives from provider organisations are members of the Programme Board where progress, issues and risks to delivery are tracked and addressed. Clinical Board - brings together all of NW London’s medical leaders to ensure transition is being safely planned and managed and will coordinate collective action to address any issues as required. Monitoring - Clinical Board and Programme Board continue to review and monitor key metrics on activity, quality and shape change. Implementation Business Case – The ImBC is acting as a Strategic Outline Case (SOC) for the reconfiguration outlined by SaHF. All dependent organisations, including CCGs and Trusts will need to give formal support for the ImBC (and the reconfigurations it outlines). A baseline for significant event activity levels has been created from which we can track the impact of changes made through reconfiguration. We have a shared communication protocol with Trust communication leads so that we are all delivering the same message 	<p>Mitigating actions: <i>(What more should we do?)</i></p> <table border="1"> <tr> <td>Continue to review programme governance structures as we progress through implementation</td> <td></td> <td></td> </tr> <tr> <td>Submission of Implementation Business Plan to NHS England</td> <td>Mar 16</td> <td>D of S&T</td> </tr> <tr> <td></td> <td></td> <td></td> </tr> <tr> <td></td> <td></td> <td></td> </tr> </table>	Continue to review programme governance structures as we progress through implementation			Submission of Implementation Business Plan to NHS England	Mar 16	D of S&T																																		
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<p>Assurances: <i>(How do we know if the things we are doing are having an impact?)</i> Implementation decisions are being made through a CCG assurance process.</p>	<p>Gaps in assurance: <i>(What additional assurances should we seek?)</i> These will be identified through the internal and external assurance process and managed through the programme governance structure.</p>																																								
<p>Current performance: <i>(With these actions taken, how serious is the problem?)</i> The governance process is well supported by all organisations indicating that all are working together to mitigate the risk.</p>	<p>Additional Comments :</p>	17																																							

Objective 6: Empowering staff to deliver our statutory and organisational duties		Director lead: Chief Finance Officer																																								
Risk 18 – Finance: Risk that we do not achieve our financial duties in 2015/16, as well as ensuring the longer term financial stability and security of the system, whilst remaining within the management spend budget.		Date last reviewed: September 2015																																								
<p>Risk Rating (likelihood x consequence): Initial: 3 x 5 = 15 Current: 3 x 5 = 15 Appetite: 1 x 5 = 5</p>	<table border="1"> <caption>Risk Rating Data</caption> <thead> <tr> <th>Month</th> <th>Risk Score</th> <th>Risk Appetite</th> </tr> </thead> <tbody> <tr><td>Apr</td><td>15</td><td>5</td></tr> <tr><td>May</td><td>15</td><td>5</td></tr> <tr><td>Jun</td><td>15</td><td>5</td></tr> <tr><td>Jul</td><td>15</td><td>5</td></tr> <tr><td>Aug</td><td>15</td><td>5</td></tr> <tr><td>Sep</td><td>15</td><td>5</td></tr> <tr><td>Oct</td><td>15</td><td>5</td></tr> <tr><td>Nov</td><td>15</td><td>5</td></tr> <tr><td>Dec</td><td>15</td><td>5</td></tr> <tr><td>Jan</td><td>15</td><td>5</td></tr> <tr><td>Feb</td><td>15</td><td>5</td></tr> <tr><td>Mar</td><td>15</td><td>5</td></tr> </tbody> </table>	Month	Risk Score	Risk Appetite	Apr	15	5	May	15	5	Jun	15	5	Jul	15	5	Aug	15	5	Sep	15	5	Oct	15	5	Nov	15	5	Dec	15	5	Jan	15	5	Feb	15	5	Mar	15	5	<p>Rationale for current score: There are significant pressures relating to acute sector over performance, running cost budgets and QIPP delivery. The long term financial landscape remains challenging.</p> <p>Rationale for risk appetite: Achieving financial duties is a core requirement and, therefore, the likelihood of this must be minimised.</p>	
Month	Risk Score	Risk Appetite																																								
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<p>Controls: <i>(What are we currently doing about the risk?)</i></p> <ul style="list-style-type: none"> Budgets approved by governing bodies at the start of the year. Contracts for 2015/16 agreed with transformation outcomes explicit. Contract performance is being actively reviewed on an on-going basis. Local CCG Finance & Performance committees are scrutinising finance reports and monitor QIPP and investment plans. Risk pooling across the CCG's in CWHHE is in place. Financial strategy across the 8 NWL CCGs is agreed. Recovery targets for overspending budgets have been set and budget holders will be held to account for delivery. 		<p>Mitigating actions: <i>(What more should we do?)</i></p> <table border="1"> <tbody> <tr> <td>Review acute sector performance and agree remedial actions</td> <td>Sep 15</td> <td>MDs</td> </tr> <tr> <td>Rigorous review of underlying position</td> <td>Sep 15</td> <td>CFO</td> </tr> <tr> <td>Revision of 5 year plans</td> <td></td> <td>CFO</td> </tr> </tbody> </table>		Review acute sector performance and agree remedial actions	Sep 15	MDs	Rigorous review of underlying position	Sep 15	CFO	Revision of 5 year plans		CFO																														
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<p>Assurances: <i>(How do we know if the things we are doing are having an impact?)</i> Governing Bodies receive regular finance reports including investment plans, QIPP plans and deep-dive contract reviews. Audit committee receives reports from internal audit on the operation of system controls.</p>		<p>Gaps in assurance: <i>(What additional assurances should we seek?)</i> Need to strengthen the governance links from contract monitoring through committees to the governing body.</p>																																								
<p>Current performance: <i>(With these actions taken, how serious is the problem?)</i> QIPP delivery is both slower and lower than required. There is a significant rise of over-performance on acute contracts.</p>		<p>Additional Comments:</p>																																								
			18																																							

Risk Scoring Matrix (Source – National Patient Safety Agency)

Consequence scores

Choose the most appropriate domain for the identified risk from the left hand side of the table Then work along the columns in same row to assess the severity of the risk on the scale of 1 to 5 to determine the consequence score, which is the number given at the top of the column.

	Consequence score (severity levels) and examples of descriptors				
	1	2	3	4	5
Domains	Negligible	Minor	Moderate	Major	Catastrophic
Impact on the safety of patients, staff or public (physical/psychological harm)	Minimal injury requiring no/minimal intervention or treatment. No time off work	Minor injury or illness, requiring minor intervention Requiring time off work for >3 days Increase in length of hospital stay by 1-3 days	Moderate injury requiring professional intervention Requiring time off work for 4-14 days Increase in length of hospital stay by 4-15 days RIDDOR/agency reportable incident An event which impacts on a small number of patients	Major injury leading to long-term incapacity/disability Requiring time off work for >14 days Increase in length of hospital stay by >15 days Mismanagement of patient care with long-term effects	Incident leading to death Multiple permanent injuries or irreversible health effects An event which impacts on a large number of patients
Quality/complaints/ audit	Peripheral element of treatment or service suboptimal Informal complaint/inquiry	Overall treatment or service suboptimal Formal complaint (stage 1) / Local resolution Single failure to meet internal standards Minor implications for patient safety if unresolved Reduced performance rating if unresolved	Treatment or service has significantly reduced effectiveness Formal complaint (stage 2) complaint Local resolution (with potential to go to independent review) Repeated failure to meet internal standards Major patient safety implications if findings are not acted on	Non-compliance with national standards with significant risk to patients if unresolved Multiple complaints/ independent review Low performance rating Critical report	Totally unacceptable level or quality of treatment/service Gross failure of patient safety if findings not acted on Inquest/ombudsman inquiry Gross failure to meet national standards

Human resources/ organisational development/staffing/ competence	Short-term low staffing level that temporarily reduces service quality (< 1 day)	Low staffing level that reduces the service quality	Late delivery of key objective/ service due to lack of staff Unsafe staffing level or competence (>1 day) Low staff morale / Poor staff attendance for mandatory/key training	Uncertain delivery of key objective/service due to lack of staff Unsafe staffing level or competence (>5 days) Loss of key staff /Very low staff morale No staff attending mandatory/ key training	Non-delivery of key objective/service due to lack of staff Ongoing unsafe staffing levels or competence / Loss of several key staff No staff attending mandatory training /key training on an ongoing basis
Statutory duty/ inspections	No or minimal impact or breach of guidance/ statutory duty	Breach of statutory legislation Reduced performance rating if unresolved	Single breach in statutory duty Challenging external recommendations/ improvement notice	Enforcement action Multiple breaches in statutory duty Improvement notices Low performance rating Critical report	Multiple breaches in statutory duty Prosecution Complete systems change required Zero performance rating Severely critical report
Adverse publicity/ reputation	Rumours Potential for public concern	Local media coverage – short-term reduction in public confidence Elements of public expectation not being met	Local media coverage – long-term reduction in public confidence	National media coverage with <3 days service well below reasonable public expectation	National media coverage with >3 days service well below reasonable public expectation. MP concerned (questions in the House) Total loss of public confidence
Business objectives/ projects	Insignificant cost increase/ schedule slippage	<5 per cent over project budget Schedule slippage	5–10 per cent over project budget Schedule slippage	Non-compliance with national 10–25 per cent over project budget Schedule slippage Key objectives not met	Incident leading >25 per cent over project budget Schedule slippage Key objectives not met
Finance including claims	Small loss Risk of claim remote	Loss of 0.1–0.25 per cent of budget Claim less than £10,000	Loss of 0.25–0.5 per cent of budget Claim(s) between £10,000 and £100,000	Uncertain delivery of key objective/Loss of 0.5–1.0 per cent of budget Claim(s) between £100,000 and £1 million Purchasers failing to pay on time	Non-delivery of key objective/ Loss of >1 per cent of budget Failure to meet specification/ slippage Loss of contract / payment by results Claim(s) >£1 million
Service/ business interruption Environmental impact	Loss/interruption of >1 hour/ Minimal or no impact on the environment	Loss/interruption of >8 hours Minor impact on environment	Loss/interruption of >1 day Moderate impact on environment	Loss/interruption of >1 week Major impact on environment	Permanent loss of service or facility Catastrophic impact on environment

Table 2 Likelihood score (L)

What is the likelihood of the consequence occurring? The frequency-based score is appropriate in most circumstances and is easier to identify. It should be used whenever it is possible to identify a frequency.

Likelihood score	1	2	3	4	5
Descriptor	Rare	Unlikely	Possible	Likely	Almost certain
Frequency How often might it/does it happen	This will probably never happen/recur	Do not expect it to happen/recur but it is possible it may do so	Might happen or recur occasionally	Will probably happen/recur but it is not a persisting issue	Will undoubtedly happen/recur, possibly frequently

Table 3 Risk scoring = consequence x likelihood (C x L)

	Likelihood				
Likelihood score	1	2	3	4	5
	Rare	Unlikely	Possible	Likely	Almost certain
5 Catastrophic	5	10	15	20	25
4 Major	4	8	12	16	20
3 Moderate	3	6	9	12	15
2 Minor	2	4	6	8	10
1 Negligible	1	2	3	4	5

For grading risk, the scores obtained from the risk matrix are assigned grades as follows

	1 - 3	Low risk
	4 - 6	Moderate risk
	8 - 12	High risk
	15 - 25	Extreme risk