BOARD ASSURANCE FRAMEWORK

CWHHE

Objective 1: Enabling people to take more control of their health and wellbeing	**Director lead:** Managing Directors
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:** February 2016

Risk Rating

(likelihood x consequence):

Initial: 4 x 4 = 16

Current: 4 x 4 = 16

Appetite: 2 x 4 = 8

25
20
15
10
5
0
Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar
Risk Score
Risk Appetite

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 is 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?)*

<u>**Culture change and leadership**</u>

WSIC Workforce Group: recruitment, training and development

PPG Development: investment in supporting effective development of PPGs

Ealing CCG have been working on establishing Network based PPG groups, with a primary focus on promoting self-care and self-management as requested by the membership.

Self-care delivery group established with all partners across Ealing assessing all current programmes which has led to a self-care strategy in line with NWL WSIC self-care framework.

Information and Advice Network established with Local Authority and local voluntary sector partners overseeing the delivery of tools such as self-care directory, Healthy Ealing Web Portal, Care Place and other online resources for local residents and patients.

Central London CCG have appointed a Governing Body clinical lead for self-care.

The Managing Director for **Central London CCG** meets with the User Panel Chair and wider User Panel formally and informally.

<u>**Systems:**</u> **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

H&F – community grant programme launched

<u>**People**</u>

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?)***:**

Action	Timescale	Lead
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 Services and Whole Systems, both across NW- 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/ MH
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.	Ongoing	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 performance 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; and • Strengthened assurance of Public Health programme delivery.	
Current performance: *(With these actions taken, how serious is the problem?)*	**Additional Comments**	**1**

BOARD ASSURANCE FRAMEWORK

CWHHE Central London, West London, Hammersmith & Fulham, Hounslow, Ealing. Clinical Commissioning Groups

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 NHS England assurance framework due to complexities of multi-agency working (especially in the case of looked after children placed out of borough) and the way tier 4 child and adolescent mental health services (CAMHS) are commissioned, leading to a child being seriously harmed.	**Date last reviewed:** February 2016

Risk Rating

(likelihood x consequence):

Initial: 3 x 5 = 15

Current: 2 x 5 = 10

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

- 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 framework for serious incidents to CCGs that identifies assurances has been strengthened;
- 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;
- recruitment of a third clinical safeguarding post; and
- perinatal commissioning across three boroughs.

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

Action	Timescale	Lead
Continue to monitor risks relating to mobile families, taking further action as appropriate	Ongoing	JW
Continue to work as an agency across the system to help identify risks to individuals and respond accordingly	Ongoing	JW

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

- 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;
- NHS England's 'deep dive' in Oct 15; and
- Annual Safeguarding report in Nov 15.

[Risk scoring reduced in light of final two points above]

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

- 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; and
- impact of health visitor commissioning transferring to Local Authorities from NHS England.

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

Key risk factor is children placed out of borough with health needs require the co-operation of LAC teams in other boroughs. Children requiring CAMHs tier 4 treatment are the responsibility of NHS England.

Additional Comments

Risks around systems to monitor mobile families.

2

CWHHE Central London, West London, Hammersmith & Fulham, Hounslow, Ealing. Clinical Commissioning Groups

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 NHS England assurance framework across all the services that we commission, leading to an adult being seriously harmed.	**Date last reviewed:** February 2016

Risk Rating

(likelihood x consequence):

Initial: 4 x 4 = 16

Current: 2 x 5 = 10

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; and
- contracts and SLA's for Named GPs and Designated Doctors have been reviewed.

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

Action	Date	Lead
Action plan to be updated for 2016/17	Feb 16	JW
Ascertain how compliant the CCGs are with the deprivation of liberty Supreme Court ruling at Cheshire West	Mar 16	JW
Continue to monitor CQC reports into primary care, addressing any ongoing concerns with safeguarding training that may arise	Ongoing	JW

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;
- working group established 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;
- NHS England's 'deep dive' in Oct 15; and
- Annual Safeguarding report in Nov 15.
- [RAG rating reduced in light of final two points above]

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

- 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; and
- 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 savings required.

3

CWHHE Central London, West London, Hammersmith & Fulham, Hounslow, Ealing. Clinical Commissioning Groups

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:** February 2016

Risk Rating

(likelihood x consequence):

Initial: 4 x 4 = 16

Current: 4 x 3 = 12

Appetite: 2 x 4 = 8

Rationale for current score:

Following the recent acquisition, the risk is that the separate elements of the Trust continue to operate in a pre-acquisition manner and do not realise the mutual benefits of merging, as set out in the business case.

Rationale for risk appetite:

Contract management and other processes aim to reduce the likelihood of issues 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?)*

- 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; and
- approach to commissioning across Hounslow and West London CCGs agreed and in place.

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

Action	Date	Lead
Continue to work with the existing contract, quality and performance structure	On going	MD
Clarity to be sought on CCG representation on the foundation trust Board of Governors	Feb 16	BW
Continue to monitor on compliance with the Care Act 2014, acting on any concerns as they may arise.	ongoing	JW

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

- 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; and
- initial transition to new organisation has progressed smoothly with new CEO in place and visibility of leadership across the entirety of the organisation.

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

- 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; and
- assurances gained at Clinical Quality Group didn't align with CQC report. We need to tighten clinical engagement with the trust.

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

- Serious incident reporting at Chelsea and Westminster shows a different profile from other acute Trusts in NW London. Work is underway to understand and address this issue.

Additional Comments

4

BOARD ASSURANCE FRAMEWORK

CWHHE Central London, West London, Hammersmith & Fulham, Hounslow, Ealing. Clinical Commissioning Groups

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

Director lead: Managing Director, H&F 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: February 2016

Risk Rating

(likelihood x consequence):

Initial: 4 x 4 = 16

Current: 4 x 4 = 16

Appetite: 2 x 4 = 8

Rationale for current score:

Imperial provides acute services to all 8 CCGs in NWL. H&G CCG has a responsibility as co-ordinating commissioner to up to 75 CCGs. The relationship between the CCG, Imperial, referrers and commissioners system-wide, as well as with the NHS England and the TDA needs careful management.

Rationale for risk appetite:

Combination of strategic and technical commissioning approaches and processes in active use to identify and manage issues and risks with greatest possible impact.

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

- 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;
- a daily call to update on operational challenges and actions is held between senior CCG and Trust management staff;
- 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;
- an integrated approach, with joined up working with NHS England specialised commissioning team, Trust Development Agency and NHS England assurance teams;
- a range of approaches in place including clinical assurance testing, audits and walk the pathway visits to areas of strategic focus; and
- a remedial action plan is in place for RTT performance improvement and a plan for A&E 4hr performance improvement is close to being agreed.

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

Action	Timescale	Lead
Formal contract action through use of the full range of contract levers if provider performance falls below expected standards	Through 15/16	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	MD & CP
Connect up in and out of hospital pathway commissioning, working with referrers as well as Imperial team	Through 15/16	MD & CP

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

- 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;
- weekly clinical quality meetings are held between the CCG quality lead with the trust to monitor quality concerns. E.g. Serious incident reporting and investigations, Infection control, the quality and timeliness of discharge information;
- joint monitoring with TDA of Imperial's progress against its action plan in response to CQC reports; and
- 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.

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

- 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; and
- assurance required that infection control systems are embedded across the organisation.

Current performance: *(With these actions taken, how serious is the problem?)*	**Additional Comments**	
• 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; and • 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.	• delivery of Trust transformational programme must show an impact; • the Urgent Care Centre at St Mary's has been re-tendered and a new provider is in the process of mobilising a service launch; and • the CIS re-procurement is underway and any transition to a new model of provision will need to be managed carefully.	**5**

BOARD ASSURANCE FRAMEWORK

CWHHE Central London, West London, Hammersmith & Fulham, Hounslow, Ealing. Clinical Commissioning Groups

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:** February 2016

Risk Rating (likelihood x consequence):

Initial: 5 x 4 = 20

Current: 5 x 4 = 20

Appetite: 2 x 4 = 8

25
20
15
10
5
0
Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar
Risk Score
Risk Appetite

Rationale for current score:

There are concerns regarding the financial position 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 undertaken in January; and
- Associates' meetings with other commissioners.

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

Action	Timescale	Lead
Continued actions through Clinical Quality Group and Performance & Contracting Executive meetings	Ongoing	MD
Working with the Trust, BHH and the TDA to understand the Trust's Cost Improvement Plans and capital development plans	Ongoing	MH
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	MH

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 ;
- performance trajectory for ED performance; and
- 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;
- community paediatrics' staffing numbers;
- awaiting the outcome of the CQC visit for LNWH which included the Ealing Hospital site;
- require assurances that there is adequate management in place to deliver the Ealing community services given some of the vacancy issues; and
- detail underpinning the recovery plan particularly understanding CIPs for the Trust in 1617 and areas where they are looking for additional income from the CCG.

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

- RTT performance is below contracted levels performance is not improving; Ealing ICO operating at a high vacancy rate; financial position is a concern.

Additional Comments

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

6

CWHHE Central London, West London, Hammersmith & Fulham, Hounslow, Ealing. Clinical Commissioning Groups

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:** February 2016

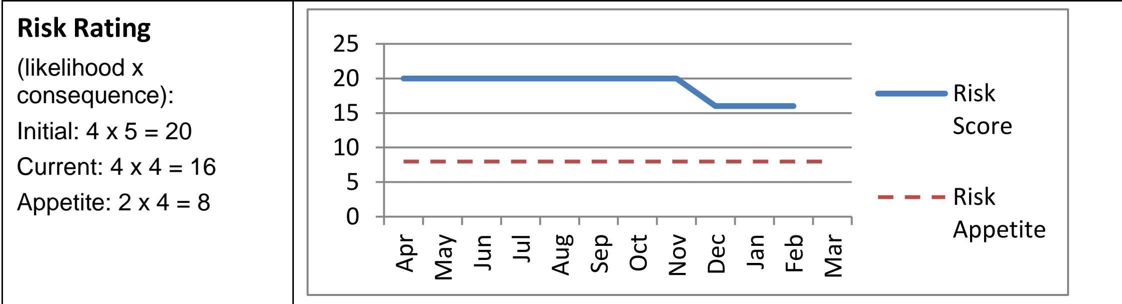
Risk Rating

(likelihood x consequence):

Initial: 4 x 5 = 20

Current: 4 x 4 = 16

Appetite: 2 x 4 = 8



Rationale for current score:

Delivery of Out of Hospital strategy is dependent on the community nursing and whole systems integrated care models being implemented. Under the the Specialist Housing Scheme for Older People programme, care homes have transferred to the new provider and risks relating to the procurement exercise have reduced.

Rationale for risk appetite:

Successful design and implementation will potentially deliver improvements to patient experience and outcomes.

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

- A programme to oversee delivery of the improvement plan is in place which reports to the CLCH contract performance committee; and
- CLCH have agreed with the principle that we pass day to day management of community nurses to GP localities.

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

Action	Timescale	Lead
Agree and monitor WL WSIC as SDIP as part of 2016/17		MB
~~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

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

- Quality and Performance report;
- monitoring of WL WSIC programme to ensure performance is covered as part of the agenda;
- are our service users actively engaged; and
- Is CLCH working in partnership with other organisations GP providers and acute Trust?

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

- Evidence of effective service user engagement
- The ability of CLCH to actively engage with other providers to ensure seamless transition of services and improve service user experience.
- Lack of assurance regarding contingencies to reduce impact to service users if CLCH is unable to maintain safe and effective service levels.

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

- 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;
- podiatry for Central London CCG is being scrutinised for its access/waiting times performance; and
- performance relating to CQUIN compliance is currently less than 30%.

Additional Comments

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.

There have been a number of positive discussions about the strategic direction for the Trust which are more in line with the whole systems strategy.

7

CWHHE Central London, West London, Hammersmith & Fulham, Hounslow, Ealing. Clinical Commissioning Groups

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:** February 2016

Risk Rating

(likelihood x consequence):

Initial: 4 x 4 = 16

Current: 3 x 4 = 12

Appetite: 2 x 4 = 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.

Rationale for risk appetite:

Measures are being put in place aiming to reduce the likelihood of problems arising with service levels.

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

- 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;
- Like-minded strategy being developed across NWL; and
- regular commissioner discussions.

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

Action	Timescale	Lead
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/KE

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

- Updates and mental health issues presented to governing bodies by the lead commissioner; and
- Mental health Trust engaging with local Health and Wellbeing Boards.

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

- 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 and other investments during the year; and
- underperforming against IAPT access target for Ealing – Contract Query Notice in place and both commissioner and provider working to drive improvement.

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

Performance falling below expected levels in some areas.

Additional Comments

- Shifting Settings of Care discharge - there is low trajectory of the overall target for discharges made into enhanced primary care; and
- H&FCCG 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:

- staffing levels;
- financial position;
- service transformation and capacity to deliver change; and
- Bed capacity – Care Quality Commission Report.

Date last reviewed: February 2016

Risk Rating (likelihood x consequence):

Initial: 4 x 5 = 20

Current: 3 x 5 = 15

Appetite: 2 x 4 = 8

25
20
15
10
5
0
Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar
Risk Score
Risk Appetite

Rationale for current score:

There are concerns that the quality of services provided by the Trust is not meeting expectations, as evidenced by the Care Quality Commission reviews and Monitor report. The Trust is engaging with the CCG to make improvements. In light of actions implemented following the CQC report risks have been reduced; however, work needs to continue.

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.

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

- 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; and
- Clinical Quality Group focussing on how Care Quality Commission findings will be addressed.

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

Action	Timescale	Lead
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	Jan 16	LP/JW

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

- Quality, Patient Safety & Risk and Finance & Performance Committees report directly to Governing Bodies; and
- Reports to Clinical Quality Group.

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

- 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; and
- address variability in national IAPT targets.

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

- Given the expansion to provide services at Milton Keynes and the current two enforcement notices, concerns remain.

Additional Comments : the Carnall Farrar review of mental health services across North West London will help us to address this risk.

'Like-minded' strategy will drive transformation of services for future models of care.

9

CWHHE Central London, West London, Hammersmith & Fulham, Hounslow, Ealing. Clinical Commissioning Groups

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:** February 2016

Risk Rating (likelihood x consequence):

Initial: 4 x 4 = 16

Current: 4 x 4 = 16

Appetite: 2 x 4 = 8

Rationale for current score:

At present staffing levels and vehicle deployment are such that response time targets are not being met.

Rationale for risk appetite:

With the successful delivery of the performance improvement plan we hope that performance will improve and the likelihood of harm being much reduced.

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

- 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; and
- appointing clinical team leaders to help change organisational culture.

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

Actions identified at the shadow patient outcomes committee meeting in January to be considered and implemented locally.	Feb/Mar 16	Chairs/MDs

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

- 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; and
- monthly CQG meeting to which GPs/clinical leads are invited.
- New CWHHE quality and performance committee reviewed LAS performance and quality in January. Actions identified for local implementation.

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

- Exception reports not adequately aligned to provide assurance that the performance improvement plan is delivering.

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

- 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; and
- demand (activity) levels are currently below forecast. LAS performance is variable and hovering around the current agreed performance trajectory.

Additional Comments :

10

CWHHE

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: February 2016

Risk Rating (likelihood x consequence):

Initial: 4 x 5 = 20

Current: 4 x 5 = 20

Appetite: 2 x 5 = 10

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 requirements on commissioners for ensuring the safety and welfare for the patients they are responsible for placing.

Rationale for risk appetite:

This reflects the unpredictability of the failure of the care home/ domiciliary care provider system.

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

- Co-operation 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 Mental Capacity Act project being led by Bucks University;
- working with the Local Authorities and CQC to predict and identify risks in the system; and
- Safeguarding training for CCG staff.

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

Action	Lead	Date
Evaluate the effectiveness of the pathway for NHS funded care	JW	Mar 16
Cooperate with Safeguarding Adult Boards to implement the learning from Safeguarding Adult Reviews in relation to the care system	JW	ongoing
~~Ensure placements are made primarily on the basis of clinical need and safety~~	~~JW/SJ/JC~~	~~Dec 15~~
~~Review key performance indicators and performance of CHC and FNC~~	~~JW/SJ/JC~~	~~Dec 15~~

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

- Provider concerns reports to part 2 of QPSRs and Governing Bodies; and
- Director to Director meetings for failing providers in conjunction with the Local Authority.

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

Assurance of appropriate medical cover in Care Homes, as well as wider health services in working with care providers:

- 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; and
- CCGs' role in Deprivation of Liberty to be clarified.

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

The quality of provision delivered by care homes /domiciliary care continues to give cause for concern.

Additional Comments :

Under the Specialised Housing Scheme for Older People, five out of six care homes have transferred to the new provider and these are supported by regular contract review meetings which include quality aspects.

11

CWHHE Central London, West London, Hammersmith & Fulham, Hounslow, Ealing. Clinical Commissioning Groups

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: February 2016

Risk Rating

(likelihood x consequence):

Initial: 4 x 4 = 16

Current: 4 x 4 = 16

Appetite: 2 x 4 = 8

Rationale for current score:

CCGs have an important role in supporting the development of Federations, including preparing these new organisations for assurance and implementing new structures to deliver out of hospital services. Workforce issues remain.

Rationale for risk appetite:

There is no national contract for commissioning Federations; therefore CCGs are in new territory.

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

- 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; and
- **Central London** – new leadership at the central London Federation.
- H&F – appointments made to posts within Federation to enable key work streams to be taken forward
- H&F – Federation and Imperial have entered in to a Memorandum of Understanding with the intention of moving forward with ACP activities
- H&F – CEPN established and concentrating on workforce issues
- H&F - PPG development work funded by Federation in order to improve patient feedback

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

Action	Date	Lead
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	Feb 16	JW/MDs
Indicators for monthly integrated performance and quality reports to be developed	Jan 16	AB
Continue discussion with Local Authority regarding development of joint approach to recruitment and retention of health and social care staff locally	To end of 15/16	CP
Increasing quality capacity at CCG level	Dec 15	JW

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

- Feedback from patients and practices; and
- monthly monitoring of OOH contracts by F&P Committees

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

- Spring 2016: out of hospital service specification final review; and
- Organisational Development plan for each Federation.

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

Additional Comments :

Local Medical Committees' input is essential to the success of Federations.

12

CWHHE Central London, West London, Hammersmith & Fulham, Hounslow, Ealing Clinical Commissioning Groups

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

Director lead: Chief Officer

Risk 13 – Primary Care co-commissioning: risk that the structures and behaviours established to jointly commission primary care with NHS England:

- do not enable us to commission the change required to deliver our strategy;
- adversely affect relationships with member practices;
- create significant conflicts of interest; and
- there is not the finance or capacity to deliver

and lead to challenges in delivering the change to services in our plans.

Date last reviewed: February 2016

Risk Rating

(likelihood x consequence):

(likelihood x consequence):

Initial: 4 x 4 = 16

Current: 3 x 4 = 12

Appetite: 3 x 3 = 9

Rationale for current score:

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. Local meetings have taken place and processes are becoming clearer hence a reduction in the risk score in early 2016.

Rationale for risk appetite:

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?)*

- 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;
- 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;
- on-going engagement with the LMC through the joint committees and existing regular forums through the CCGs and the strategy and transformation team; and
- co-commissioning CoI addendum and original joint committee TOR were agreed with NHS England and approved by all five governing bodies.

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

Action	Timescale	Lead
Further revisions might be required to respond to issues that arise from the practical functioning of the committees.	On-going	MH
Ensure actual and potential declarations of interest are effectively managed.	On-going	All have a responsibility
Ensure that lessons learned from other CCGs are captured to inform the on-going development of this work.	On-going	MH

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

- 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; and
- 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?)*

- 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; and
- 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?)*

- 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; and
- NHS England 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 :

- 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.

13

CWHHE Central London, West London, Hammersmith & Fulham, Hounslow, Ealing. Clinical Commissioning Groups

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:** February 2016

Risk Rating

(likelihood x consequence):

Initial: 4 x 4 = 16

Current: 3 x 4 = 12

Appetite: 2 x 4 = 8

Rationale for current score:

We need to bring our stakeholders, including member practices, The LMC, the local authority, MPs, providers and the public, with us on the journey which will involve difficult decisions and changing models of care. Risk reduced to 12 in light of engagement programmes underway.

Rationale for risk appetite:

By engaging we hope to reduce the likelihood that we don't achieve the intended improvements.

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

- 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;
- H&F: – Governing Body approved new engagement way forward document in November 2015;
    - community grant programme launched with funding decisions due at the end of February 2016;
    - community engagement event held in December 2015 to seek views on commissioning intentions and future engagement opportunities;
    - participation in LBHF community events to seek residents' views on current health services;
    - Ipsos MORI 360 participants reviewed in order to ensure more comprehensive responses to questionnaire;
    - CCG officers attending wide range of community events and meetings in order to hear community views and provide information on local services;
- Tri-borough – equalities workshop held in February 2016 to review previous equalities objectives and set actions for next three years; and
- CCGs have started or are in the process of communicating and engaging with patients with regard to PMS review.

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

Action	Timescale	Lead
Ensure actions arising from the annual Ipsos MORI 360 stakeholder survey are targeted and implemented	Annual	MD
Need to ensure good engagement with the primary care co-commissioning agenda	On-going	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. Completed in H&F and new plan approved by GB in November 2015	On-going	MD

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

- Health & Wellbeing Boards discuss key issues with senior CCG leaders; and
- annual Ipsos MORI 360 stakeholder survey shows improvement since previous year.

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

None identified.

Current performance: *(With these actions taken, how serious is the problem?)*	**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.	**14**

Objective 4: Establishing a collaborative and proactive culture with partners and the people we commission services for	**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:** February 2016

Risk Rating (likelihood x consequence):

Initial: 5 x 3 = 15

Current: 4 x 3 = 12

Appetite: 4 x 3 = 12

Chart: Risk Score and Risk Appetite, Apr–Mar (y-axis 0–25)
Legend: Risk Score; Risk Appetite

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. Even though we have strengthened our arrangements, the inherent conflicts of interest within the way we are structured means that we are not comfortable with reducing the risk score at this stage. Risk reduced in light of further assurances and revised policy.

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.

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

- 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 revised and 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; Six-monthly reviews of CoI registers.
- 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;
- 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;
- implemented an approach to managing investments where these is a conflict using lessons learned from recent procurements.

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

Action	Lead	Date
Governing Body members and other identified colleagues to be provided with (refresher) conflict of interest training to be linked to learning from recent procurements.	BW	2016/17
Reissue Codes of Conduct for NHS staff	BW	Mar 16
Reissue a reminder to all staff about compliance with CCG policies	BW	Mar 16

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

- 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; and
- Registers of Interest complete and up to date and published on websites.
- Internal Audit report gave positive assurances.
- NHS England assured our CoI arrangements as part of primary care co-commissioning arrangements

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

- 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 maintains training records in order to ensure that all members of the Governing Body have completed the training. Each CCG to update register of gifts and hospitality and publish.

Current performance: *(With these actions taken, how serious is the problem?)*	**Additional Comments** : Primary care joint commissioning arrangements will be monitored to ensure conflicts of interest are effectively managed.	**15**

Objective 4: Establishing a collaborative and proactive culture with partners and the people we commission services for	**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: • 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; and • IT systems that make good use of technology.	**Date last Reviewed:** February 2016

Risk Rating (likelihood x consequence):

Initial: 4 x 4 = 16

Current: 4 X 4= 16

Appetite: 2 X 4= 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.

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

- 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; and
- 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?)*:

Continue work with HENWL to ensure required resources are in place and appropriately trained	Ongoing	MH
Strategic Workforce Plan to be taken to governing bodies. January seminars then March governing bodies.	Mar 16	MH

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:** February 2016

Risk Rating (likelihood x consequence):
Initial: 4 x 4 = 16
Current: 3 x 4 = 12
Appetite: 2 x 4 = 8

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.

Rationale for risk appetite:

If these changes are not delivered it will quickly impact quality and safety of services across NWL.

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

- **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; and
- We have a **shared communication protocol** with Trust communication leads so that we are all delivering the same message.

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

Action	Date	Lead
Continue to review programme governance structures in line with the recent review as we progress through implementation	Mar 16	BW/MH
Submission of Implementation Business Plan to NHS England	Mar 16	MH

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

Implementation decisions are being made through a CCG assurance process.

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

These will be identified through the internal and external assurance process and managed through the programme governance structure.

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

The governance process is well supported by all organisations indicating that all are working together to mitigate the risk.

Additional Comments :

17

CWHHE Central London, West London, Hammersmith & Fulham, Hounslow, Ealing. Clinical Commissioning Groups

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:** February 2016

Risk Rating (likelihood x consequence):

Initial: 3 x 5 = 15

Current: 2 x 5 = 10

Appetite: 1 x 5 = 5

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. Risk reduced as risks relating to 15/16 have been mitigated; risks relating to longer term financial stability remain.

Rationale for risk appetite:

Achieving financial duties is a core requirement and, therefore, the likelihood of this must be minimised.

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

- 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 is in place;
- recovery targets for overspending budgets have been set and budget holders will be held to account for delivery;
- A service level agreement is in place with SBS which states all CCG issues will be resolved in 5 working days;
- An issues log is maintained by Systems & Project Support. This is discussed at conference calls between the CCG and SBS.

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

Action	Timescale	Lead
Revision of 5 year plans	In line with national timetable	KE
Find an enhanced way to performance manage SBS against the terms of the service level agreement, working with NHS England as contract leads.	2016/17	KE
Conduct a review of SBS usage across all CWHHE CCGs to capture all risks and issues to encourage proportionate management of the risk at scale (as a single CCG cannot resolve the risk).	2016/17	KE

Note – SBS if the provider of procurement services to the CCGs.

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

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.

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

Whilst a financial strategy is in place across the 8 NW London CCGs it is not formally agreed.

Need to strengthen the governance links from contract monitoring through committees to the governing body.

CWHHE Central London, West London, Hammersmith & Fulham, Hounslow, Ealing. Clinical Commissioning Groups

Current performance: *(With these actions taken, how serious is the problem?)* QIPP delivery is both slower and lower than required. There is a significant rise of over-performance on acute contracts. SBS Oracle Software is sub-optimal for CCGs' financial management reporting of financial transactions between budget holders and providers. The level of service support the CCGs receive from SBS has a negative impact on the accuracy of CCGs' month and year end reporting. Slow payments through SBS for Personal Health Budgets, could have a negative impact on patient health. SBS - On-going negative impact to month end and year end accuracy. Oracle doesn't record activity which has a negative impact on 'over and under' contract payments.	**Additional Comments:**	**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 breech of guidance/ statutory duty	Breech of statutory legislation Reduced performance rating if unresolved	Single breech in statutory duty Challenging external recommendations/ improvement notice	Enforcement action Multiple breeches in statutory duty Improvement notices Low performance rating Critical report	Multiple breeches 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