Objective 1: Securing high quality services for patients and reducing the inequality gap.

Director lead: Jonathan Webster

Risk 1: Quality of services (central/smaller contracts): risk that we do not take adequate consideration of service quality as a result of failing to monitor core quality requirements do not monitor the right elements of the new services leading to unnecessary harm.

Date last reviewed: October 2016

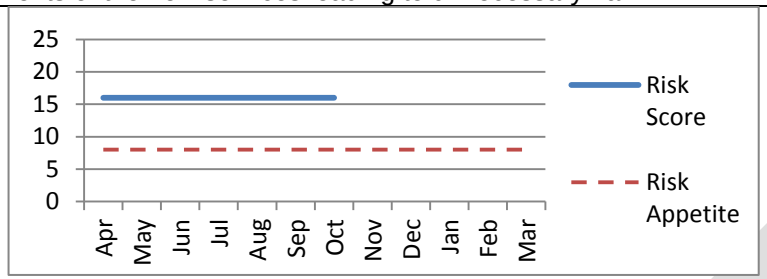
Risk Rating

(likelihood x consequence):

Initial: 4 x 4 = 16

Current: 4 x 4 = 16

Appetite: 2 x 4 = 8



Rationale for current score:

As we set up new contracts for services in local settings there is a risk that we do not have sufficient focus on quality. This is a relatively high likelihood as we have a high number of smaller contracts and centrally managed contracts and are introducing new contracts, particularly with primary care providers.

Rationale for risk appetite:

We currently have variation across the 5 CCGs and we are aiming for consistency. A consistent approach and understanding, leading to action, will reduce the likelihood of this risk occurring.

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

- Quality leads in place across all five CCGs to provide assurance on safeguarding, quality improvement and clinical assurance across commissioned providers.
- Dedicated quality lead for the centrally managed contracts function (managed by BHH)
- Out of Hospital Services Steering Group and six-month review process – additional quality lead appointed to work with Federations to work towards quality standards.
- Care home Quality Surveillance meetings (held jointly with the LA and CQC) which allow a view of all quality risks across care homes and domiciliary providers, chaired by NHSE.
- Quality Surveillance meetings which allow a view of all quality risks across NWL commissioned providers (September 2016)
- Provider Concerns meetings – emerging risks are identified and mitigations put in place.
- Contract meetings with care homes for assurance that all contractual and quality specifications are being met. (October 2016)
- 3 and 12 monthly reviews of patients funded by the NHS - Funded Nursing Care, Continuing Health Care CHC teams.
- CCG and small contract briefing to SMT Proposing review of quality, finance and QIPP risks in contracts across CCGs was agreed. (September 2016)

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

Action	Date	Lead
Ealing CCG to lead short focussed review of all local CCG contracts by externally commissioned body to give a risk overview based on identified criteria, at individual CCG level. Outcome to be shared across the 4 CCGs	Late 2016	TS
Set up Clinical Quality Groups or similar arrangements to monitor quality of services provided through smaller contracts – with robust quality indicators to enable objective reporting and assessment.	Pending review of contracts	JW/TS
We will implement the recommendations of the Internal Audit review of continuing care packages.	Various dates	JC
We are taking forward with the aim of embedding the process for quality monitoring for OOH contracts.	On-going	JW
Finalise contracts database and incorporate quality indicators within that.	Early 2017	AB
Contracts database reviewed at Finance and Performance committee meetings	Early 2017	MDs

Assurances: *(How do we know if the things we are doing are having an impact?)* Internal Audit review into contracts, updates reported to the Audit Committees. Quality Committees receive reports on service quality, through the integrated quality performance reports on a monthly basis. Contract monitoring meetings held with providers where exceptions in quality indicators are discussed, clinically challenged and action plans monitored.

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

Full visibility of all contracts is being developed but not yet finalised. Systems need to be embedded to ensure CCGs have visibility of all quality issues within services provided.We are setting up new contracts particularly with primary care providers and quality reporting mechanisms are not uniform.

Patient experience is reviewed – improvements and challenges are noted with actions to improve. (Monthly)		
Current performance: *(With these actions taken, how serious is the problem?)* - Central contracts have implemented the core quality schedule and are able to identify quality concerns. - CCG held contracts – quality risks are not specified across all contracts and this will need further scoping for the size and relative risk. - Paper outlining the current CCG positions i.e. number of contracts and financial range, was presented to SMT on 12/09/2016. This paper presented options which were agreed individually by CCGs. External review was chosen by Ealing HF, West central & Hounslow identified that work is already underway on this.	**Additional Comments** - Establishment of Dashboard reporting should be beneficial. - Increased risk of not focusing on quality when setting contracts for services across providers and not sufficient focus on clinical governance arrangements across providers.	**1**

Objective 1: Securing high quality services for patients and reducing the inequality gap.

Director lead: Jonathan Webster

Risk 2: Assurances (larger contracts): risk that our assurance mechanisms are found to be insufficient leading to significant quality issues emerging and a diversion of resources away from planned interventions.

Date last reviewed: October 2016

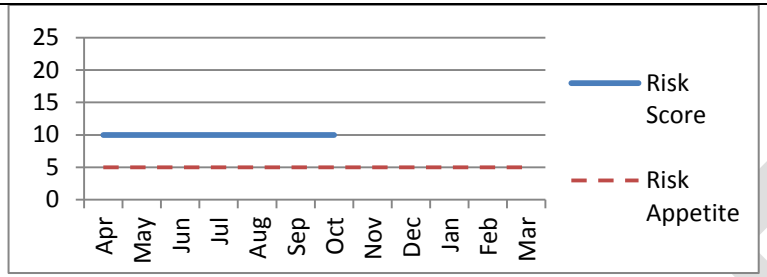
Risk Rating

(likelihood x consequence):

Initial: 2 x 5 = 10

Current: 2 x 5 = 10

Appetite: 1 x 5 = 5



Rationale for current score:

There is a low probability but high impact risk that our assurance mechanisms do not give sufficient visibility to emerging issues. This is because we rely on our providers being open to challenges and risks to quality of services and responding to concerns arising from the triangulation of complaints, patient experience and patient safety as well as soft intelligence from GPs and the wider healthcare environment.

Rationale for risk appetite:

We want to reduce the likelihood of the risk materialising by continuing to work closely with providers to commission safer services this will mitigate some risk however this scoring acknowledges that there is inherent high risk within healthcare that can be catastrophic for the patient.

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

- Clinical Quality Group meetings - agendas and reporting mechanisms
- CCG quality committees and CWHHE Quality & Performance Committees, and the visibility they provide.
- Feedback mechanisms – eg West London CCG receives / collates feedback from patients and member practises about services to strengthen their data.
- This is a priority focus in the Sustainability and Transformation Plan.
- Regular clinical visits to providers.
- Where there are areas of addition assurances needed, this is taken through the CQG or through individual meetings with the trust.

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

Action	Date	Lead
Additional clinical site visits to seek assurance where there are areas of concern.	Continuous	JW
Additional time allocated from the CCG quality team to providers facing challenges in relation to patient safety reporting; learning from serious incidents; improving patient experience reports through engagement processes.	Continuous	JW
Quarterly or more frequently if required infection control visits to seek assurance.	Continuous	JW
Increased CCG safeguarding team visits to support safeguarding leads in providers where there are concerns.	Continuous	JW
We will continue to use existing assurance mechanisms, triangulating these with external assurances such as CQC reports and direct patient/carer feedback, and be aware that assurance gaps may still exist.	Continuous	JW

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

Minutes and actions from the Clinical Quality Committees are reported to the CCG's Quality Committee. (Monthly)

The triangulation of information allows the CCGs to have a more comprehensive picture

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

Discussion required at regular intervals to ensure we are minimising the risk Through formal contractual mechanisms, or outside of those meetings, with a report back in to the CCGs Quality & Patient safety committees.

of concerns – if there is no improvement having assessed and worked with the provider then this can be formally escalated through Clinical Quality Group to the provider trust. Director lead for quality for focussed action and improvement. For example receiving more timely reporting of serious incidents and evidence of learning may show an increase in reporting of lower harm incidents. The provider reports quarterly on safeguarding, infection control and patient experience. This should provide evidence of improvement alongside the CCGs patient safety quarterly review in topatient safety incidents and learning.		
Current performance: *(With these actions taken, how serious is the problem?)* Standardised quarterly reporting templates have been developed for use by all providers for infection control, safeguarding and patient experience this has shown better reporting over the past 6 months however gaps remain in relation to the impact of referral to treatment times, pressure ulcer management in some providers, access to specialist mental health services commissioned by NHSE London.	**Additional Comments**	**2**

Objective 2: Enabling people to take more control of their health and wellbeing through information and ill-health prevention.

Director lead: Matthew Hannant

Risk 3: Long Term Condition Prevention and Management: risk that we do not take action now to help people stay healthy and support patients with long term conditions leading to worsening population health and more pressure on the health and social care system that could have been avoided.

Date last reviewed: October 2016

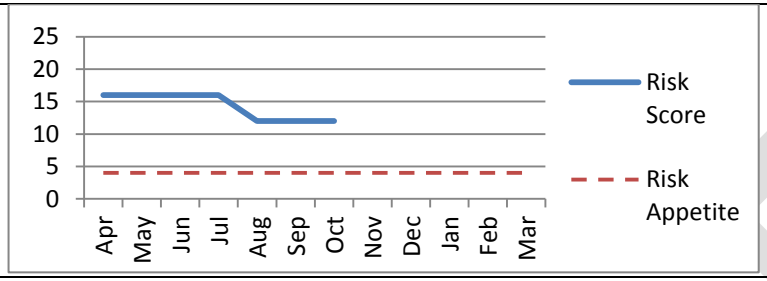
Risk Rating

(likelihood x consequence):

Initial: 4 x 4 = 16

Current: 4 x 3 = 12

Appetite: 2 x 2 = 4



Rationale for current score:

If we do not focus resources now on preventing ill-health and managing patients who already have one or more long term condition(s) then we will experience increased demand on services. Currently there is not enough focus on this area.

Rationale for risk appetite:

We want to reduce the likelihood and the impact. Reducing the impact is a long-term intention going well beyond the 12 month timeline shown here.

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

STP Delivery Area 1 – Prevention and self-management- Supporting self-care through use of patient activation measurements; Health Coaching training to help staff to have motivational conversations with patients; NW London Healthy workplace charter;
Primary care and specialist community nurse workforce development, and expanding programme to build carers' skills around setting achievable health and wellbeing related goals for patients.
Number of business cases being developed including; alcohol prevention, smoking cessation and childhood obesity
National diabetes prevention programme participation.
Out of hospital services – diabetes care contract.
NHS right care programme.
Patient Engagement events' focus on healthy eating / lifestyle.
Primary Care Navigators (or equivalent) provide support for patients with long-term conditions
Hounslow CCG strategic objectives include the review of LTC specifications including self-care.

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

Action	Date	Lead
Prevention delivery area 1 of the STP	Completed	PE/JW
S&T actively working with WLA to address prevention	Completed	PE/JW
Local Services team initiated wider developments of Health programme to tackle employment, housing, and social isolation	Completed	PE/JW
Identifying patients at risk	TBC	TBC
Director of Public Health developing business cases for prevention investment	Dec 2016	PE/JW
Managing patients more effectively	TBC	TBC
Completion of scoping exercise. To move to a more integrated way of delivering diabetes care.	TBC	TBC
More comprehensive and integrated approach to managing long term conditions needs to be developed via Right Care	Jan 2017	PE
Reprocurement of community contracts – cardio respiratory	TBC	TBC
Piloting patient self-management system, part of Self Care programme – delivery PAM	Mar 2017	PE
Local Services Programme includes health & lifestyle support	Completed	PE

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

Strategic Planning Group (last held on 13 October 2016)/ STP bringing unifying CCG,

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

Robust and regular impact indicators.
Dashboards on how we are doing with managing long-term conditions (links to the

Local Authority and Provider approach to prevention. CCG & LG SROs and joint delivery teams	Right Care programme). Specific, objective assurances require development, including reporting on joint-working with Public Health. Formal feedback loops indicating how prevention programmes and public health activities contribute to the control this risk. Delivery areas are working on all of these aspects and more information will be available as plans develop	
Current performance: *(With these actions taken, how serious is the problem?)*	**Additional Comments**	**3**

Objective 3: Delivering strategic change programmes in the areas of primary care, mental health, integrated care and hospital reconfiguration.

Director lead: Matthew Hannant

Risk 4: Provider workforce: risk that we do not have the workforce required to deliver our strategy and new models of care.

Date last reviewed: October 2016

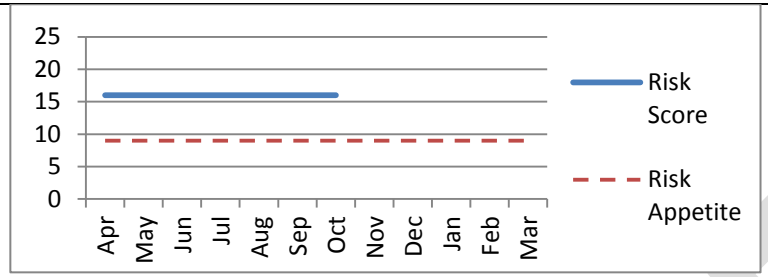
Risk Rating

(likelihood x consequence):

Initial: 4 x 4 = 16

Current: 4 x 4 = 16

Appetite: 3 x 3 = 9



Rationale for current score:

If we do not deepen our understanding of future workforce needs and ensure there are sufficient training programmes to train the future required workforce, and staff are not supported to develop into new roles, we will not be able to effectively commission and deliver new models of care.

Rationale for risk appetite: By taking action we can reduce both the likelihood and the impact. Models of care to support the delivery of the SCF are being developed and the workforce model to support this is not currently known

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

Practice manager development and young practitioner emerging leadership support to build capability in provider to address workforce transformation.

Health Education NW London funded integrated workforce working with each CCG to understand baseline of workforce and competencies in providers and supporting the development of workforce plans to support new models of care.

Dedicated nurse rotation programme funded by HEE NWL to support nurses to move from acute to community and primary care settings to increase workforce supply and support retention in NWL.

Develop new models of care based on available workforce to improve productivity by using staff more appropriately.

Project to address issues around high levels of expected GP and practice nurse retirement to support workforce resilience.

Re procuring the Change Academy phase 2 programme which will be better aligned to the STP priorities and support systems leadership by targeted to support for senior leaders, transformational leaders and front line teams.

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

Action	Date	Lead
Broad view of workforce needs needs to be refined locally based on the planning around delivery of SCF.. Need clear plans for each CCG around new models of care that describe the workforce needs/transformation to support delivery. The Workforce Transformation Team, London Workforce Partnership and HEE NWL are working together to develop workforce modelling at a CCG level to support development of plans that acknowledge likely workforce gaps.	Strengthening Care Teams sub group meetings 28 Oct, 18 Nov & 9 Dec 2016	Richard Ellis leading the SCF

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

A revised governance proposal for two new groups has been agreed, which will reflect and support the delivery of the emerging STP priorities. The two groups are the NWL Workforce Transformation Advisory Council and a NWL Workforce Transformation Delivery Board (informed by the Advisory Council). The proposed Groups will be chaired by Dr Ethie Kong along with a LA rep and HEE North West London Local Director.

The Transformation Delivery Board will meet every 4-6 weeks and the Advisory Council will meet once per quarter. The first meetings of this new group will be on 8 November.

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

The development of the models of care is being supported through the SCF Implementation Project Delivery Group which has representation from each CCG who will represent the CCG and feedback to the CCG.

In the absence of defined new models of care, we don't know what workforce we will need therefore we cannot define training courses required to help realise the new workforce, we are supporting the system to understand current workforce availability to make sure that the models of care take account of labour market conditions and develop thinking at as early a stage as possible to think about innovative ways to use the existing workforce in innovated ways to address any gaps.

	The Sustainability and Transformation Plan will have an aggregate of the NW London requirement.	
Current performance: *(With these actions taken, how serious is the problem?)* HEE NWL have two schemes to develop practice nurses in NWL, one for existing practice nurses to increase their skills and competence and one to support nurses from other sectors to move into practice nursing. Work continues to make GP training placements in NWL attractive to trainees with over 95% fill rates for placements over the last 5 years supporting continued recruitment of GPs to NWL.	**Additional Comments** CLCH is aligning community nursing to West London's Whole Systems hubs – evaluation will be required.	**4**

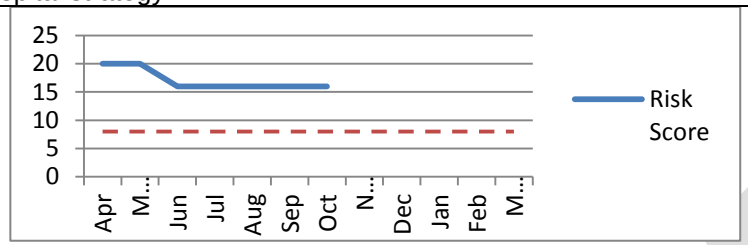
Objective 3: Delivering strategic change programmes in the areas of primary care, mental health, integrated care and hospital reconfiguration.

Director lead: Matthew Hannant

Risk 5: Primary Care: risk that primary care is unable to deliver the required services due to lack of ability to act at scale, workforce, or estates issues, preventing us from delivering our Out of Hospital strategy.

Date last reviewed: October 2016

Risk Rating
(likelihood x consequence):
Initial: 5 x 4 = 20
Current: 4 x 4 = 16
Appetite: 2 x 4 = 8



Rationale for current score: Primary care is being relied upon to address the growing demand for services to be delivered locally – without investing appropriately we will not be able to deliver sustainable change. CCG's infrastructure to effect change across general practice and primary care remains limited. Risk score reduced due to new internal team in place to manage local services transformation.

Rationale for risk appetite: We want to reduce the likelihood.

Controls: *(What are we currently doing about the risk?)*
Co-commissioning decision making structure is in place – 2015.

The PMS review is the first stage of the work to equalise the offer to patients in primary care. PMS commissioning intentions agreed with NHS England – 2015

Team in place to write the primary care estates strategy. Timescale dependent on the survey data – this will complement the strategic estates plan already in place.

Talking to local authorities about accessing monies paid to local authorities by developers to contribute to infrastructure improvements, including healthcare, under section 106 of the Town and Country Planning Act 1990. We are working with them to invest this money in primary care facilities across CWHHE CCG area

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

Action	Date	Lead
Discussion across CWHHE CCGs on our views of the future of primary care commissioning.	Dec 2016	CP
Workshop for chairs, to re-energise/recast the new models of care work (across NW London)	Completed	MH
CCGs working with S&T to develop local delivery plans for the access component of the SCF	Dec 2016	PE
GP Access funding for SCF extended access	Funding level confirmed and now dependent upon robust plans	PE
New Models of Local Services care working group established, programme plan in 3 sections developed, SCF delivery – care coordination	July 2016 – On-going	PE
Local services outcomes under development. Due to be trialled in the winter 2016.	Winter 2017	PE
Local services is a key comp of STP and detailed plans are under development	Dec 2016	PE

Assurances: *(How do we know if the things we are doing are having an impact?)*
Minutes of the Primary Care Co-commissioning Committee meetings and JCIC meetings.
Five local care service hubs (incorporating primary care services) being established across CWHHE CCG area.

Gaps in assurance: *(What additional assurances should we seek?)*
Awaiting confirmation from NHS E of the next steps and timelines for the PMS review.
Co-commissioning committee considering applications for the primary care estates and technology transformation fund. Confirmation of bid outcomes expected in

Oversight and development processes for Local Services (six projects), Implementation Business Case and Like-Minded. GB oversight of NWLSC delivery and planning (September/October 2016)	August 2016 from NHSE. Local services dashboard not yet in place – due to be trialled in the Summer 2016. GP practices' responses about CCGs in the stakeholder survey are awaited. Need to consider whether changes need to be made to our organisational structure/workforce to help drive this work and whether CCGs can prepare for any further devolution of NHS England's functions and workforce.	
Current performance: *(With these actions taken, how serious is the problem?)* West London CCG, practices may face financial challenges as a result of introducing out of hospital services	**Additional Comments** Once the workshop agrees the timetable for the new models of care business case, we can progress this work – the business case will assure the governing body that we are addressing this area of risk.	**5**

Objective 3: Delivering strategic change programmes in the areas of primary care, mental health, integrated care and hospital reconfiguration.

Director lead: Ben Westmancott

Risk 6: Conflicts of Interest: risk that we do not manage conflicts of interests adequately leading to commissioning decisions being challenged, a loss of confidence in the CCG, and slowing down of the pace of change.

Date last reviewed: October 2016

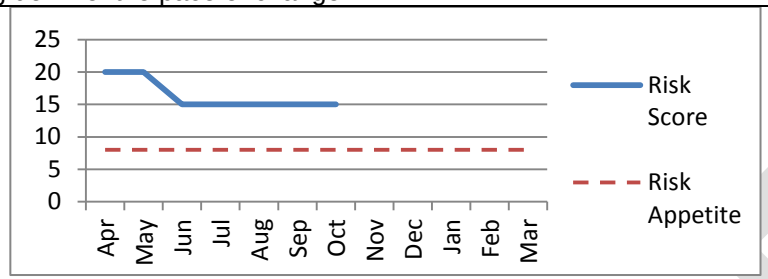
Risk Rating

(likelihood x consequence):

Initial: 4 x 5 = 20

Current: 3 x 5 = 15

Appetite: 2 x 4 = 8



Rationale for current score:

If this risk is not mitigated, there is a high risk of decision making that is challengeable given the inherent conflict of interests within CCGs. Risk score reduced for 3 of 5 CCGs where constitutional changes have been made in relation to numbers of lay members and delegation. Internal policy and procedures have been reviewed supporting reduction of the risk.

Rationale for risk appetite:

There will always be a residual risk on non-compliance with policies and procedures; we can only ensure that the systems are simple, accessible and easy to understand.

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

- Independent Investment Committee at CCGs' disposal when conflicts arise at GB level;
- Conflicts of Interest Policy – updated January 2016, review again post-NHS England revised guidance, c. October 2016
- Training for governing body members (should be available from NHS E from November 2016)
- 6-monthly review of governing body declarations of interest
- Declarations of interest sought and recorded at all decision-making meetings
- Training / responsibilities of Governance Leads and CCG Officers supporting decision making.
- Governance leads meet weekly to progress issues relating to the management of conflicts of interest.

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

Action	Date	Lead
Update our Conflicts of Interest Policy	Q4 16/17	BW
Appoint a conflicts of interest guardian	Q4 16/17	BW
Establish and deliver a training programme for all staff / Governing Body members / decision-makers	Q4 16/17	BW
Review of CCGs' constitutions to ensure clear and robust provisions	Q4 16/17	BW
Establish a reporting mechanism for breaches of the policy	Q4 16/17	BW
Development of common and interrogable NWL declarations of interest (and gifts and hospitality) database	Q4 16/17	BW

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

Annual audit with results reported back to the Audit Committee. (Audit March 2017)
Published register of interests - scheduled reviews and updating (6 Month review)
Use of Investment Committee to scrutinise processes for managing conflicts of interest in expenditure decisions and dissemination of lessons learned. (Monthly)

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

Need to establish a reporting mechanism for breaches of the policy – this is being developed through the policy revision process.

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

Constitutional review underway, initial amendments made in three CCGS.
Working group has been established to unify a policy across the 8 NWL CCGs, including GP and Lay members.
Short form 'conflicts of interests basics' guidance drafted for all staff and decision makers will be disseminated in November.

Additional Comments

NHSE launched additional consultation on conflicts of interest on 19/09/2016, policy review process etc. extended to Q4 to 16/17 to accommodate the results of the consultation.

6

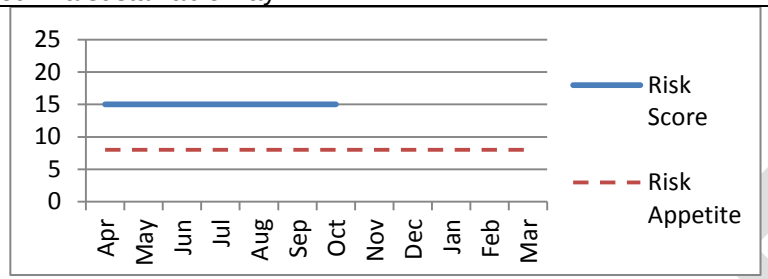
Objective 4: Working with stakeholders to develop strategies and plans.

Director lead: Matthew Hannant

Risk 7: Sustainability and Transformation Plan: risk that if we do not agree a workable plan across NW London then we cannot enable services across health and social care to be delivered in a sustainable way.

Date last reviewed: October 2016

Risk Rating
(likelihood x consequence):
Initial: 3 x 5 = 15
Current: 3 x 5 = 15
Appetite: 2 x 4 = 8



Rationale for current score:
We need to be able to agree across NWL a plan for sustainability and transformation.
In order to develop the plan we need engagement and ownership from organisations across NWL.

Rationale for risk appetite:
We want to reduce both the likelihood and the impact of this.

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

Baseline Sustainability and Transformation Plan in place.
Strategic Planning Group across NW London in place with agreed terms of reference.
In the process of establishing Joint Health & Care Transformation Group to oversee development of the STP and its delivery.
STP NHS and local government communications network has been established.
STP Engagement Strategy developed.
Collaboration Board across 8 NW London CCGs in place.
Lay Partner Forum across NW London providing scrutiny in place.

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

Action	Date	Lead
Baseline and developing Sustainability and Transformation Plan discussed at Governing Body seminars in June 2016	Completed	MH
Summer programme of public engagement undertaken. Public events continue across NW London to update the public on our emerging plan and to hear views. More than 1100 people have visited the NW London online engagement site, and over 100 face-to-face surveys have also taken place.	Summer / Autumn 2016	MH
Initial Sustainability and Transformation Plan submitted in June	Completed	MH
Submission of final Sustainability and Transformation Plan due on 21 October	21 October 2016	MH

Assurances: *(How do we know if the things we are doing are having an impact?)*
Individual programme management boards in place with assurances back to CCGs Last meetings held;
DA1 – 21 September 2016
DA2 &3 – 10 October 2016
DA4 – 23 September 2016
DA5 – 18 October 2016

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

Gap analysis required between STP and existing plans.

Feedback from eight engagement events with providers, patients, Healthwatch, carers and their families and lay partners has been fed into the STP.		
Current performance: *(With these actions taken, how serious is the problem?)* No evidence of significant gaps at this stage given timelines. On track to submit final STP to NHS England by 21 October 2016. Currently establishing programme boards for each delivery areas. Focus is on mobilising activity, ensuring we deliver 16/17 plans and develop plans for 17/18 and 18/19.	**Additional Comments**	**7**

Objective 5: Strengthen the organisation's infrastructure to help us deliver high quality commissioning.

Director lead: Maggie Gibbs

Risk 8: Pace of change and prioritisation: risk that we try to take on too many change programmes leading to loss of focus, ineffective delivery, unintended impacts on equalities, organisational fatigue, and difficulties in retaining high calibre staff.

Date last reviewed: October 2016

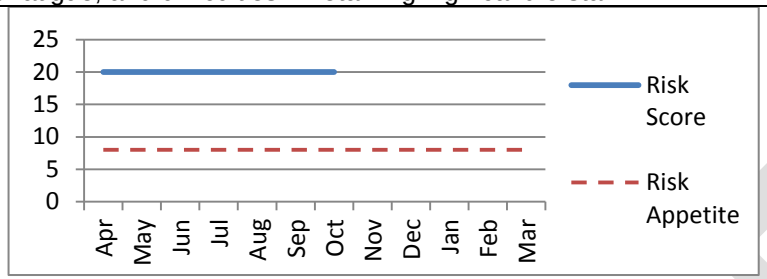
Risk Rating

(likelihood x consequence):

Initial: 5 x 4 = 20

Current: 5 x 4 = 20

Appetite: 2 x 4 = 8



Rationale for current score:

Without prioritisation and programmes in place to help us work more effectively, there is a high risk that we will become overburdened.

Rationale for risk appetite:

By prioritising work and supporting staff to work smarter, we can focus attentions and be more successful and reduce the likelihood of the risk materialising.

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

Organisational Development programme in place including local action based OD Working Groups in each CCG, Collaborative wide 'breaking the cycle' events, Collaboration wide health & well-being initiative and learning and development programme.

Each CCG has a business plan for the year that was approved at Governing Body meetings in March 2016.

Prioritisation of CCG plans took place at start of the year.

Central London CCG's turnaround team in place and operational.

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

Action	Date	Lead
Middle management leadership programme to be launched.	Oct 2016	MG
London Healthy Workplace Charter mark base level to be achieved by Central London, West London, Hammersmith and Fulham, and Hounslow CCGs.	Summer 2016	MG
Breaking the cycle events throughout the year. Next programme scheduled for September 2016	On-going	LB
Improve appraisal rates, objective setting and supervision to help staff to prioritise workload.	Sep 2016 - Mar 2017	MG
Regular reporting on appraisal and objective setting compliance rates following the establishment of a central database which should be in place by end October 2016.	Late October 2016	PC
Following a review of Insite development work is being drawn up to improve its functionality.		

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

Ealing CCG and Central London CCG have already achieved commitment level in the London Healthy Workplace Charter. Strategy & Transformation have submitted and are awaiting accreditation results. West London CCG and Hammersmith & Fulham CCG are developing their application. Hounslow CCG is considering whether to commit time and resource to the initiative.

Register of high risk projects will be reported to the Senior Management Team on a monthly basis.

Monthly HR report on staff turnover and vacancies reported locally and at SMT.

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

HR data could be presented at Governing Body meetings.

A central collection of appraisal data and assessment of quality of appraisals is being developed. There needs to be a strong focus on improving appraisals rates and objective setting to help staff to prioritise workload and align their work to the corporate objectives.

Need to improve internal communications tools including content and processes. *Insite* is improving but still not being used to its full capabilities.

The CWHHE workforce reports are also presented at Finance and Performance meetings. The impact of the OD programme is measured via the annual staff survey. The findings of the last staff survey have been shared with all CCGs and local OD action plans developed. This will shape future organisational direction.		
Current performance: *(With these actions taken, how serious is the problem?)* We have improved procedure for the use and deployment of interims and Contractors as previously stated. This has moved in a different direction now as a result of the new regulations on Interim Approvals. We are now required to get approval (3 different levels depending on cost and duration of contracts) from NHS England. This has added an extra level of complexity to the process but it does strengthen the internal controls.	**Additional Comments** Current initiatives should tackle the risk that has been identified with the intention of reducing the level. There are no new concerns.	**8**

Objective 5: Strengthen the organisation's infrastructure to help us deliver high quality commissioning.

Director lead: Bill Sturman

Risk 9: Data and information: risk that we do not make effective use of the data across the health and social care system and turn it into meaningful information, shared appropriately, to support effective decision making and improvements to delivery of care.

Date last reviewed: October 2016

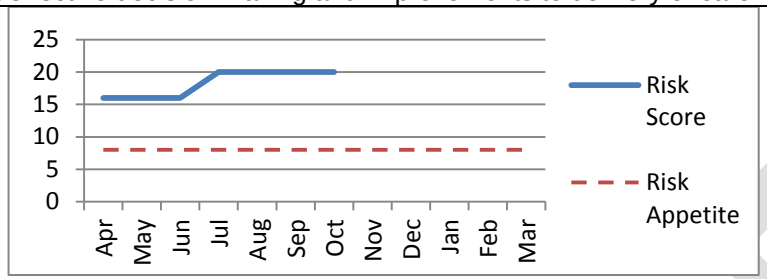
Risk Rating

(likelihood x consequence):

Initial: 4 x 4 = 16

Current: 4 x 5 = 20

Appetite: 2 x 4 = 8



Rationale for current score:

We know we could be making better use of information systems and that is leading to the procurement of a new system. Uncontrolled we will continue to not have all the information we need. Risk has increased due to uncertainty with the procurement of an improved system.

Rationale for risk appetite:

By using what we have more effectively and by designing future internal and multi-agency systems well, we can reduce the likelihood of this risk materialising.

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

WHYSE business (healthcare) intelligence system in place.

Draft specification for the new business intelligence tool is being consulted on internally.

Business Intelligence managers in each CCG.

Modern GP IT infrastructure.

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

Action	Date	Lead
Awareness sessions on existing Business Intelligence tools.	Throughout the year	BS
New terms of reference and profile for a Data Quality Management group	Complete (Oct 2016)	BS
Local Digital Roadmap production including analytics	Complete (Oct 2016)	MD
Information Governance training for specialist commissioning leads within CWHHE CCGs.	By March 2017	BW
Procurement of a new Business Intelligence system to replace existing contract when it expires on 1 April 2017. Key risks and mitigations are: a) Clarification of new system requirements – Business case and collected requirements are being approved by GBs prior to tendering for a solution. b) Clear governance process – A steering group including CCG Chairs, Chief Officers, CFOs, Lay Members and Directors has been established to monitor progress and report to CWHHE and BHH Governing bodies c) Contract expiry before new system procured and implemented - Discussions have begun with the NHSE in terms of extending existing system usage. NWL own systems can provide continuity as a backup.	Throughout the year	IR
Whole systems integrated care dashboard being developed.	Dec 16	IR

Assurances: *(How do we know if the things we are doing are having an impact?)* Reporting of BI progress to Collaboration Board and BI procurement to GBs (September 2016)	**Gaps in assurance:** *(What additional assurances should we seek?)* Need to establish commissioning BI requirements for GBs and sub-committees. Data Quality issues to be raised by new DQM group.	
Current performance: *(With these actions taken, how serious is the problem?)* Newly procured system meeting identified BI needs should significantly reduce this risk.	**Additional Comments** Mapping of all information sharing agreements across health & social care should be beneficial and improve consistency of approach.	**9**

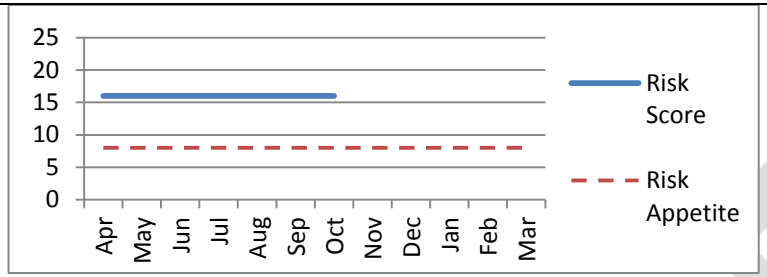
Objective 5: Strengthen the organisation's infrastructure to help us deliver high quality commissioning.

Director lead: Ben Westmancott

Risk 10: Governance structures: risk that governance within our CCG and across NW London is not operating in a way that enables us to make effective shared decisions. (BW)

Date last reviewed: October 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:
Operating in a collaborative way across CCGs overlaid with new structures such as the multi-agency Strategic Planning Group means that lines of accountability can get blurred.

Rationale for risk appetite:
Given the direction of travel with the STP, ACPs etc, simple, clear, transparent and accountable and robust mechanisms are required to enable development and implementation of strategies at pace whilst preserving compliance with statutory requirements and maintaining public trust and confidence.

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

Constitutions / Standing Orders / Scheme of Delegation / Standing Financial Instructions in place.

Formalised and regular training for decision makers and staff in place (requires further development).

Collaboration Agreement across CWHHE CCGs in place.

Strategic Planning Group terms of reference agreed.

Targeted use of legal advice to underpin new governance mechanisms.

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

Action	Date	Lead
Review constitutions	Oct 16 - Oct 17	BW
Reviewing committee governance across CWHHE CCGs	Oct – Dec 16	BW
Refining the content and improving the process for review of CCG risk registers	Jul 16 – May 17	BW
Review Scheme of Delegation to support effective and appropriate decision making	Q3	BW
Review governance of tri-borough local authority working	TBC	TBC

Assurances: *(How do we know if the things we are doing are having an impact?)*
Regular Internal Audit reviews and NHS England assurance exercises have not flagged material concerns with current controls, application and structures.

Gaps in assurance: *(What additional assurances should we seek?)*
Lines of accountability of functions that operate across 8 CCGs are not as clear as they could be.

Stocktake on the governance development plan including priorities and milestones to be presented to SMT and governing body members.

Current performance: *(With these actions taken, how serious is the problem?)*
Improving the robustness of the BAF as an assurance document through increased challenge and engagement of lead directors centred around the feedback from governing bodies.
Work underway with CCG governance leads to review the effectiveness of local committees.

Additional Comments
Review of Tri-borough delayed due to resource issues

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Objective 6: Empowering staff to deliver our statutory and organisational duties.

Director lead: Keith Edmunds

Risk 11: Managing within financial control totals: risk that we do not achieve financial control totals across the system.

Date last reviewed: October 2016

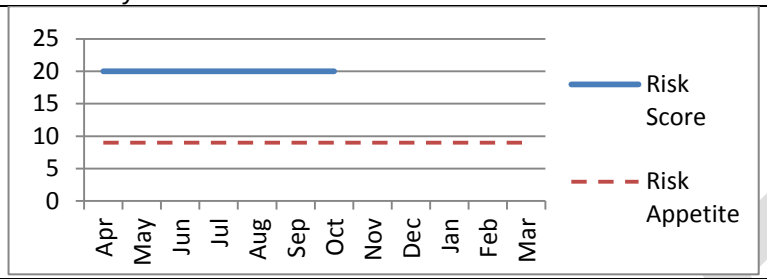
Risk Rating

(likelihood x consequence):

Initial: 4 x 5 = 20

Current: 4 x 5 = 20

Appetite: 3 x 3 = 9



Rationale for current score:

There is a high likelihood that we (across the health system) will have significant gaps in delivering financial control totals at year-end if we do not apply controls.

Rationale for risk appetite:

We want to reduce the likelihood of this risk materialising and the consequence.

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

For 16/17:

- Focus on delivery of QIPP and in year recovery plans
- Improvement in budgetary control processes
- Strengthening of collaborative working with providers to better align CCGs' QIPP savings with providers' cost improvement programmes to deliver shared savings across the system

For 17/18 and beyond:

- Development and implementation of STP to put NWL health economy as a whole on a financially sustainable footing

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

Action	Date	Lead
Establishing governance and organisation capability / capacity to manage delivery of STP	Q3, 16/17	MH
The Implementation Business Case financial assumptions are being tested with a view to putting the healthcare system in a stronger, financially sustainable, position. Due to phase due to be submitted in-year.	Submission Q4	MH
Shadow Accountable Care Partnership programme Board established, programme in development. We envisage providers working together taking responsibility for population based budgets.	In progress	DF
Developing approach to contracting for 17/18 and 18/19 aligned to STP delivery	Q3, 16/17	AB

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

- Finance reports to the Finance Committees and Governing Bodies including overall financial position, QIPP and contract performance.

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

- Need to improve understanding of activity trends across the system
- Shift focus from cost to commissioner to underlying cost to the system as a whole

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

- 16/17: CWHHE CCGs currently forecasting achievement of control totals, but require release of balance sheet reserves to do so. Underlying position has deteriorated
- Deterioration of underlying position increases risks for 17/18.

Additional Comments

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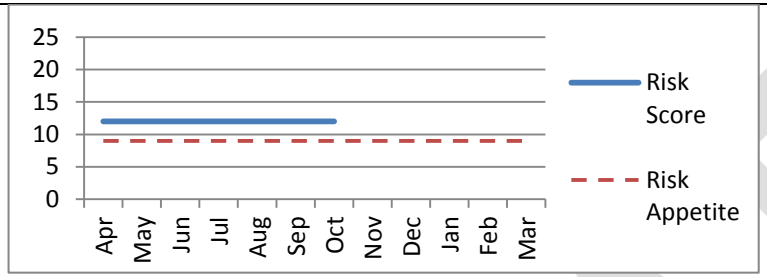
Objective 6: Empowering staff to deliver our statutory and organisational duties.

Director lead: Lizzy Bovill

Risk 12: Regulation and assurance: risk that the tension between the requirements to deliver performance, finance, quality and transformation leads to increasing or uncoordinated assurance requirements from different partners leading to duplication of effort and reduced internal capacity.

Date last reviewed: October 2016

Risk Rating
(likelihood x consequence):
Initial: 4 x 3 = 12
Current: 4 x 3 = 12
Appetite: 3 x 3 = 9



Rationale for current score:
The current score reflects improved co-ordination with NHSE over the period but the need to continue to develop this with some of our providers and NHSI.

Rationale for risk appetite:
We can reduce the likelihood of this risk materialising by having successful relationships with key leaders from our partners to ensure co-ordination of effort wherever possible. However the risk can not be mitigated completely as partners do have different governance mechanisms,

Controls: *(What are we currently doing about the risk?)*
We have an office in place that acts as a consistent link with NHS England to ensure all assurance requests that affect more than one CCG in the collaborative are managed as efficiently as possible. Robust provisions to support cross-CCG / boundary decision-making and accountability.

NHS England has published the CCG Improvement and Assessment Framework setting out the requirements for the year and how the CCGs will be assessed. Regular meetings established with NHSE to provide rolling assurance on key issues on a monthly and quarterly basis. Monthly contract performance and quality management meetings with providers to ensure responses are co-ordinated as well as regular weekly meetings between providers and commissioners to ensure to reduce duplication in responses.

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

Action	Date	Lead
Need to build informal networks with NHSI during Q3 following a change in personnel.	Dec 2016	CP
Continue to work closely with Provider colleagues to co-ordinate responses to NHSE/I over winter to maintain an STP footprint response	Jan 2017	LB

Assurances: *(How do we know if the things we are doing are having an impact?)*
NHS England assurance exercises reported to SMT and Governing Bodies. NHSE received co-ordinated responses from CWHHE CCGs in a timely manner. Increasingly productive and interactive relationships built with key provider leads and with NHSI.

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

Current performance: *(With these actions taken, how serious is the problem?)*
Regular 1:1s between Clare Parker and Simon Weldon to support strategic and operational issue resolution. Formal and informal meetings with NHSE from CWHHE performance teams to ensure co-ordinated response to assurance requests from NHSE. Ongoing need to maintain provider and NHSI relationships to maintain open communication and co-ordinated responses. Occasional examples of Providers and NHSI agreeing separate process from CCGs and NHSE

Additional Comment:
Lack of co-ordination between assurance partners, providers and commissioners increase the risk of not agreeing 2 yr contract for 17/19 to support STP delivery.

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