

Bristol, North Somerset and South Gloucestershire

Clinical Commissioning Group

BNSSG CCG Primary Care Commissioning Committee Meeting

Date: Tuesday 27th July 2021

Time: 9:30am

Location: Virtual meeting. Details within the calendar invite

Agenda Number :	5
Title:	Governing Body Assurance Framework and Corporate Risk
	Register (CRR) June 2021
Purnose: approval	

Key Points for Discussion:

The Primary Care Commissioning Committee oversees and seeks assurances risk relating to Primary Care. This includes risks concerning contracting, planning and strategy, financial planning and management and primary care quality, workforce, premises, and IT. The Committee is responsible for reviewing those risks that are relevant to its business and ensuring that appropriate and effective mitigating actions are in place. Risks assigned to the Committee for review are indicated on both the CRR and the GBAF. The key discussion points are:

- The risks rated at 20 and above on the CRR
- New risks added to the CRR since the last review by the Governing Body and Primary Care Commissioning Committee
- The risks recommended to Governing Body for removal and the confirmation of the relevant committees that they are assured that the actions have been sufficient to reduce the risk score

 Risks that committees have 	recommended remain on the CRR
	 review and ensure that appropriate and effective mitigations are
Recommendations:	in place for risks reported on the CRR and GBAF and specifically
	those areas relating to the Committee's remit
	 Review those risks recommended for closure to ensure the
	Committee is assured that the risk score has been sufficiently reduced
	 consider whether the Corporate Risk Register (CRR) and
	Governing Body Assurance Framework (GBAF) are an accurate reflection of the risks brought to the committee's attention
	 consider whether other objectives and risks reported on the
	GBAF fall within the committee's remit
Previously Considered By	The Corporate Risk Register and the Governing Body Assurance
and feedback :	Framework are reviewed monthly by Directors and received and

	discussed at the monthly Quality Committee, Strategic Finance Committee and Commissioning Executive meetings			
	g g			
Management of Declared	The Committee receives a register of its members declared			
Interest:	interests as a standing item. There are no declared interests relating			
	the CRR and no risks regarding the management of declared			
	interests			
Risk and Assurance:	The CRR and the GBAF show the current position of those risks scored at 15 and over using the 5x5 risk scoring matrix and the principal risks to the CCG's principal objectives			
Financial / Resource	As part of the Risk Management Framework the CRR and the			
Implications:	GBAF are used to identify the impact of risks including financial			
	risks. A moderation stage is used to ensure consistency in reporting			
	financial risks across the CCG. Financial risks reported on Directorate Risk registers are reviewed corporately and an impact			
	risk score is applied. If the risk score is reduced the risk is not added			
	to the CRR and the Directorate is informed. The budget baseline			
	applied is the CCG overall resource allocation.			
	Score Impact			
	1 small loss/risk of claim remote			
	2 Loss of 0.1% to 0.25% of budget (£1m to £3.5m)			
	3 Loss of 0.25 % to 0.5% of budget (£3.5m to £7m)			
	4 Loss of 0.5% to 1% of budget (£7m to £14m)			
	5 Loss of > 1% of budget (£14m+)			
Legal, Policy and	The CRR and GBAF are mechanisms for reporting risk and do not			
Regulatory Requirements:	have legal implications. Where there are risks relating to legal and			
How do so this no does	regulatory matters these are reported on the documents			
How does this reduce	No health inequalities issues arise from this report. The Corporate			
Health Inequalities:	Risk Register and the Governing Body Assurance Framework report significant risks; where there are risks related to Health Inequalities			
	that are over the risk scoring threshold of 15 and above or related to			
	a principal objective these will be reported.			
How does this impact on	No inequalities issues arise from this report, and there is no impact			
Equality & diversity	upon people with protected characteristics. The Corporate Risk			
	Register and the Governing Body Assurance Framework report			
	significant risks; where there are risks related to inequalities that are			
	over the risk-scoring threshold of 15 and above or related to a principal objective these will be reported.			
Patient and Public	Not applicable to this report			
Involvement:				
	The Corporate Diek Degister and Coverning Dedy Assurance			
Communications and	The Corporate Risk Register and Governing Body Assurance			
Engagement:	Framework are shared with Risk Leads, Risk Administrators and			
	Directors for monthly updating. The Corporate Risk Register is a			
Author(c);	public document available on the CCG website			
Author(s):	Sarah Carr, Corporate Secretary			
Sponsoring Director	Sarah Truelove, Chief Financial Officer			

Agenda item: 5

Report title: Corporate Risk Register (CRR) June 2021

1. Background

The Corporate Risk Register (CRR) provides assurance to the Governing Body that high level risks are addressed and that the actions taken are appropriate. Where a risk is linked to one or more of the CCGs principle objectives this is identified on the register. The Governing Body is responsible for ensuring that the CCG has properly identified risks and has appropriate controls in place to manage risk. The Governing Body approves the addition and removal of risks from the CRR. The CRR is presented on the new template agreed as part of the Risk Management Framework.

Directorate Risk Registers are reviewed and updated monthly. These feed into the CRR, which is discussed by the Executive as a standing item once a month. Each committee also reviews the CRR. The committees are reminded of their responsibility to review, scrutinise and challenge the management of risks specific to their remit. Committees are asked to consider whether they have a reviewing role in relation to any new risks added to the register; committees are also asked to assure themselves that risks recommended for removal have been appropriately reviewed and risks scores are revised appropriately. The Audit, Governance and Risk Committee receives the CRR as part of its responsibility to satisfy itself that systems and processes are in place and working. The Executive team has identify executive risk leads for specific areas. Executive risk leads review risks alongside director leads to ensure complete coverage of issues and avoid potential duplications.

1. Corporate Risk Register

Those risks rated at 20 and above on the CRR are highlighted below:

ref	risk description	current	Date	Cross
		risk	added	ref to
		score		GBAF
BNSSG	There is a risk that the extent of	4x5 =20	1.05.20	PO4
Commissioning	change/improvement required in AWP as our			
7	core mental health provider is not addressed,			
	impacting on the care and services provided to			
	the BNSSG population.			
	This risk includes the challenges of the current			
	crisis pathway that could be more effective -			
	currently there are a high number of people			
	placed out of area, high numbers of people on a			
	Section in hospital and increasing pressure on			

	the crisis team's ability to respond.			
BNSSG	Risk of failure to recover 52 week wait	4x5 =20	1.05.20	PO1
Commissioning	performance, which has wider implications due to			
10	the potential for patient harm. There is a			
	financial risk for the system due to the 19/20			
	contract stating that all 52 week breaches will			
	incur a fine which will be divided between CCG			
	and Provider of £5000 per patient per month.			
	One patient could incur multiple fines.			
	The risk of 52 week wait breaches has			
	significantly increased due to the pausing of all			
	routine activity in response to the Covid outbreak,			
	and recovery will be slower due to the additional			
	IPC requirements and continued reduction in			
	routine activity.			

2. Updates to the Corporate Risk Register

Risks added to the CRR are highlighted in red text on register. Updates to the CRR made since its last review are highlighted in blue on the register. Since the April review of the CRR by the Governing Body and PCCC below risks have been added to the CRR.

ref	risk description	current	Current	Cross
		risk	Commi-	reference
		score	tte	GBAF
UC01	UEC Programme - If there is insufficient	4x4=16	Clinical	PO9
	community urgent care capacity across BNSSG,		Executive	
	the NHS 111 First transformation programme will			
	not have the impact anticipated			
UC02	UEC Programme - ED booking for NHS 111 is	4x4=16	Clinical	P09
	currently switched off in BNSSG due to walk in		Executive	
	activity pressures. This results in the BNSSG			
	system being non-compliant with a national			
	requirement and associated reputational risk.			
Commissio	Due to AWP having a number of patients placed	4x4=16	Clinical	PO4
ning: 22	out of trust (OOT) there is a risk in ensuring		Executive	
	patients get equitable care when placed out of			
	area and, due to the bed base being outside			
	existing contractual obligations there is also a			
	financial risk to the CCG.			
Trans-	Communications Team	4x4=16	tbc	PO8
formation	If we do not have a clear, agreed work plan in			
Comms 3	place, there is a risk that the volume of work will			
	not be sustainable for the team. This could result			

	in not being able to meet the organisations key objectives and priorities, a risk that efforts are not focused in the right place, or that the stress on the team leads to sickness and absence. Key large programmes currently being managed alongside day to day activity include operational plan, organisational priorities, restoration and recovery of services, ongoing covid and mass vaccination and move to ICS and ICP development.			
Trans- formation Comms 4	Communications Team If we do not have allocated comms support for the transition of staff to the ICS, there is a risk of employee disengagement and a lack of workforce preparedness. There is also a risk that the team do not have capacity to deliver a well planned strategy leading to stress, overwhelm and staff sickness.	4x4=16		PO8
Commissio ning Directorate: Risk Ref - tbc	As a result of delays in the breast 2WW pathway There is a risk that patients will have later diagnosis of cancer. Which may result in patients coming to harm and requiring more extensive treatment and worse outcomes and psychological distress.	5x4=20	Clinical Executive Quality Committee	tbc
Trans- formation Comms 5	Communications Team RISK SCORE HAS INCREASED AND IS NOW REPORTED ON CRR There is a current resource gap with a number of planned and unplanned absence sacross internal, external and insights teams. These gaps are impacting on team capacity and ability to deliver planned work which will result in possible impact on output and deliverablesand possibly leading to stress and further staff sickness if not addressed.	5x4=20	tbc	PO8
Trans- formation Comms 6	Communications Team RISK SCORE HAS INCREASED AND IS NOW REPORTED ON CRR Due us not being able to secure a secondment extension for the Internal communications manager there is a significant risk on the impact of the deliverable of key internal communications work resulting in increased pressures across the team, lack of resrouces and skill at the right level	5x4=20	tbc	PO8

to deliver the complexity of work that needs to be		
undertaken. This will impact on wider workforce		
with Internal commnuication playing a key role in		
supporting staff and keeping them informed.		

The risk score for the risk below was reduced in April 2021 to below the threshold of the CRR. The risk was reviewed at the Clinical Executive meeting at the beginning of May 2021 and it was agreed that the risk score would not be reduced until the business case was agreed.

ref	risk description	current	Current	Cross
		risk	Commi-	reference
		score	tte	GBAF
Transfor-	As a result of:	5x3=15	Clinical	PO4
mation	CCG late take-up of the 2019/20 NHSE Wave-2		Executive	
	IPS funding			
	AWP's agreement to deliver but subsequent non-			
	prioritisation of the service			
	the COVID-19 crisis			
	there is now a risk that we do not establish the new			
	IPS service, which may result in:			
	People in secondary MH services not receiving			
	evidence-based support into paid employment			
	Our (already reduced) two year NHSE funding and			
	the opportunity it presented being lost			
	Failure to meet the national requirements for rapid			
	IPS further investment and expansion through the			
	LTP.			
	A business case is in development to address			
	issues with ongoing discussions regarding finances			

The risk score for the risk below was reduced in May 2021 to below the threshold of the CRR. The risk was reviewed at the Clinical Executive meeting at the beginning of June 2021 and it was agreed that the risk score would not be reduced given current performance. The risk will continue to be reported on the CRR

ref	risk description	current	Committ	Cross ref
		risk	ee	GBAF
		score		
Trans-	As a result of COVID 19 and the fact that routine	3x4=12	Clinical	PO1
formation	MSK services have been put on hold, there is a risk that waiting times for MSK services will		Executive	
	increase which may result in people having to wait, often in pain, for many months to see a Physio or			

for surgery		
101 Surgery		1

Risks to be recommended to the Primary Care Committee and the Governing Body for closure are detailed below. In each case the committee with oversight confirmed that it had been assured regarding the review and revision of the risk score. The Governing Body is asked to consider whether it is assured that the actions have reduced the risk score in each case. Risks below the threshold of the CRR continue to be monitored on Directorate Registers.

ref	risk description	current risk	Comm ittee	Cross ref
		score		GBAF
Commiss ioning: -	Infectious disease outbreak including high consequence	4x3=12	Clinical	PO1
12	infectious diseases. (VHF Ebola / SARS / MERS/Coronavirus)		Execut ive	
	Reasons for reduction in score:			
	Local Outbreak Management Plans led by DPH and			
	Health Protection Boards. All processes in place.			
	Rates remain low with small fluctuations as the Road			
	Map opens. Outbreaks in Education and Care Homes are low. Health figures are low with a caveat on Weston			
	Hospital outbreak.			
	Lateral Flow tests available for public use now to			
	monitor surge in positive cases. Vaccination rates			
	increasing which reduce transmission			

The below risk was approved or removal at the July Governing Body. Following this meeting there was a discussion at the Clinical Executive about the Urgent Care Risks reported on the Risk Register and it was agreed that these risks would be revisited and reviewed.

ref	risk description	current	Comm	Cross
		risk score	ittee	ref GBAF
T	LICO Decreases of the region in the officient accommittee		Oliminal	
Trans-	UEC Programme - If there is insufficient community	1x4=4	Clinical	PO9
formation	urgent care capacity across BNSSG, the NHS 111 First		Execut	
UC01	transformation programme will not have the impact		ive	
	anticipated			
	reasons for reduction in score:			
	UCSG agreed (5/5/21) to establish a programme of work			
	led by COG and 111 Clinical Leads Group to review the			
	front door model and required capacity and make			
	recommendations about adjustments needed to ensure			
	the right capacity is in the right place in time for winter.			
	Additional funding agreed for Sirona to increase capacity			
	for 2021/22 whilst broader changes to UEC system bed			

in (a.g. rollout of avetom CAC)		
in (e.g. rollout of system CAS).		
, ,		

3. Governing Body Assurance Framework

Following the Governing Body seminar in April 2021, the Executive Team have reviewed and updated the principal objectives and risks reported on the Governing Body Assurance Framework. The Governing Body reviewed and approved the adoption of the Governing Body Assurance Framework 2021/22 at its June meeting. The objectives map to those reported on the 2020/21.

Each objective continues to be assigned to a committee/s for oversight. The revised GBAF is presented to the Committee. Each committee will review the principal objectives and risks assigned to it to ensure that the information provided is line with the committee's expectations and challenge should be provided to ensure actions are being completed as expected. The table below summaries the principal objectives and risks assigned to the Primary Care Commissioning Committee for review and scrutiny.

The Committee is invited to consider whether other objectives on the GBAF fall within its remit:

Objective	Risk for oversight	risk
		score
		and
		trend
Covid: This risk relates to the delivery	As a result of the impact of Covid-19 there is a risk	2x5=10
of all objectives reported on the	that the need to focus capacity to meet the demands	
Governing Body Assurance Framework	on the system may result in the system and the CCG	
	not delivering the objectives identified in the	
	Governing Body Assurance Framework	
Integrated Care Partnerships: To	The complexity and extent of the change required to	3x4 =12
deliver personalised preventive and	set up integrated care partnerships that are capable	
proactive care at a locality and	of holding core service contracts is significant.	
neighbourhood level. By April 2022	There is a delivery risk that this opportunity will not	
core services will be delivered by	be fully realised before the April 2022 deadline.	
Integrated Care Partnerships. This will		
be underpinned by population health		
and value based principles to reduce		
variation, tackle health inequalities and		
ensure high quality care for all		

Appendices

Appendix 1 Corporate Risk Register Appendix 2 GBAF

Bristol North Somerset and South Gloucestershire Clinical Commissioning Group Corporate Risk Register June 2021

Bristol, North Som

The Corporate Risk Register features risks assessed as over the risk threshold (15) to the delivery of the CCG's strategic objectives, statutory duties and plans. It sets out the controls (actions) that have been put in place to manage the risks and planned actions to sturber reduce the risks and an assessment of current performance. The Corporate Risk Register is received by the Covering Body quarterly and reviewed by Committees monthly.

Risk is assessed by multilophy the fillediflood of a risk materialising by the fillegant of it materialising use this assessment affects of Risk Management Framework.

Risks are mapped against the CCG risk appetite to provide an indicative acceptable risk level. Where a risk maps to more than one principal objective the lowest level of risk appetite is given.

							Misks are mapped against the CCS risk a													
Risk Description If (cause) then (risk event) resulting in (effect/impact)	Principle Objective ref	entere d on register	Risk Lead (exec)	Risk Owner	unmitigated impact	Suns	management actions already in place to miligate risk (current controls) (in the current controls	current like lihood	current impact	current risk rating	target risk score	movement of current risk score		Actions to be taken(as these are completed they should be moved to actions in place)	Comment on progress	will CCG action alone mitigate risk	Risk appetite	Risk open/closed	target date for completion	last reviewed
Risk of failure to recover ASE performance, which has wider implications due to the potential for patient harm.	PO1	10.08.18 01.04.19 1.05.20	Lisa Manson	Greg Penlington	4 5		O-May-2020. Covid-19 Command & Control structure established, operational and embedded. Surge plans in place. • Contractual systems in place to monitor and manage performance through ICOPM's • System Management call process and procedure being further refined and developed • Partnership engagement in DRNSG-wide system architecture to support urgent care performance, specifically Clinical Oversight Correction of the Contraction of the Contract	ent 4	4	16	(2x5)=10	+	Clinical Executive Committee, Quality Committee	This risk is linked to the risk PDS on the GBAF (2019/20 under review) which contains more detail on this risk in relation to delivering the Urgent and Emergency Model of Caree October: Single performance recovery plan developed; managed Through AEDB & UCOB. May 2020 = System summit for actions to support WAHT recovery. Alwy-2020: Covid-19 Command & Control structure established, operational and embedded. Surge plans i place.	March 2021 no change JaniFeb 2021: During December and January there were significant outbreaks of COVID within WGH which led to the introduction of pathway changes through the WGH ED service. The system has continued to flours on ensuring that there is a safe Urgent Care service to its patients.			Open	Mar-21	Mar-21
As Above There is a risk that the extent of change/improvement required in AVP as our core mental health provider is not addressed, impacting on the care and services provided to the SNSS population. This risk includes the challenges of the current crisis parameters as the contract of	As Above	As Above 10.08.18 01.04.19 1.05.20	As Above	As Above As a Management of the Management of th	Above As Abo		Effective contract management processes with the current provider. Joint working with BSW on contract requirements Joint Planning and delivery of the Estates Project and COG leading consultation. AWPs transformation programme Driving forward the work of the Integrated Mental Health Strategy Framework to focus on prevention and defining optimal service provision that is more reflective of the needs of our population and how they present to services COG investment in Mental Health Investment Standard COG commonded 1920 contract repositations on behald of BNSSG and BSW Support provided to AWP for writer pressures	As Above	As Above	As Above	As Above (3x3) = 9	As Above	Commissioning Leadership Team / Cinical Executive	As Above This risk is linked to the risk PO6 on the GBAF (2019/20 under review) which contains more detail on Mental relative services The risk is linked to the risk PO6 on the GBAF (2019/20 under review) which contains more detail on Mental relative services. The risk is the services of the report of the rep	Oct-20: Work on flow and performance improvement continues daily via the ICC cell structure/Bronze and the June 2021: Target Operating Model signed off. Funding agreed by system to deliver long Tem Plan Metrica. May 2021: Nament or duttereaks endereasing in both Hoppstals and Cest Planear. Vaccination programme working well. BNSSG have been involved in asymptomatic surge testing for the Kent variant E484K. March 2021 Routine referrals have opened back up and the number of outbreaks on wards and levels of staff sichness have reduced. The introduction of the support to WMST in the ambitione buth has started to have an impact on hear and treat. Modelling work has started on PICU and a workshop has taken place with partners across BNSSG and ESW and as last and finish group with be formed to take the work forward. A new finance specification are being developed, ensuring that it supports the whole system with flocus on prevention. February 2021:A funding bid for the crisis pathway has been approved, due for implementation from April 21. The	As Above	As Above	As Above	As Above	As Above
As Above As Above	As Above	As Above	As Above	As Above As	Above As Abo	ove As		As Above	As Above	As Above	As Above	As Above	As Above		in a self-relies and ICDIs been been decreased assessed for the DD and CMI business with	As Above		As Above	As Above	As Above
Risk of failure to recover 52 week wait performance, which has wider implications due to the potential for patient harm. Or there is a financial risk for the system due to the 19/20 contract stating that all 52 week breaches will nour a significant of the system of t	PO1	29.11.18 01.04.19 1.05.20	Pisa Wans on As Above	Helion Hellor Hellor	4 S		Contractual systems in place to monitor and imanage performance through APG and Hospital flocussed improvement programmes. Partnership engagement in BNSSG-wide trauma and orthopaedic / MSK system working Monthly review of RTT performance inclosites including weekly updates of long waters (over 46 weeks). Congaing monitoring of patient harm through existing CCG quality governance in long-performance according to the material contracts in being utilitized to support and manage elective surgery, initially this via be predominantly urgent and cancer surgery but then long waiting patients would be profitised. - Feedback to the national and regional teams on the importance of managing patients in order and by clinical priority through the crisis period.	h 4	5 As Above	20 As Above	(2x5) = 10 As Above	↔ As Above	Commissioning Leadership Team / Cinical Executive	initially this will be predominantly urgent cancer surgery, but then long waiting patients would be prioritised feedback to the national and regional teams on the importance of managing patients in order and by dinical priority through crisis period. There is unconstraint on a regional plain for how the fines will be applied and the monies reinvested. This has been escalated via NHSEI and the COS and providen are awaiting a mesponse. There is uncertainty on the national contract with IS beyond the end of June. Even with additional capacity of IS, likely to still be a significant short fall for routine activity. As Above	long waiting lists March 2021 No new actions sanifes 2021: There are no new actions. The system are continuing with the action highlighted in the adapt and adopt programme. The new IS framework has been released and we are working to ensure we use as much IS capacity as possible within the rules of the framework. Dec 2020: There are no new actions. The system are continuing with the action highlighted in the adapt and adopt programme. The new IS framework has been released- this does provide an opportunity that is being expicted to ensure maximal capacity is commissioned to support the trusts recovery but there is also a risk that due to piviteb backage that the Is may be defining less than before. This is being worked through in readiness for new contracts at the end of December.	regional plan for how the fines will be monies reinvested. This has be escalated via NHSE/I at the CCG and providers awaiting a response.	eeen and are the SS e	G O	Am 8-51	As Above
As a result of delays in cancer pathways due to the Covid pandemic due to the rouleur effertials, reduced access to some investigations and issues of balancing the risk for patients who are shielding. There is a risk that patients will present at all lates of the result of the resu	PO1	13.04.2018	Lisa Manson	Helena Puller	5 4		Contractual systems in place to monitor and manage performance Hospital focusion dimprovement programmes Fortrightly review meetings with providers at the Cancer Cell Fortrightly review meetings with providers at the Cancer Cell Fortrightly review or cancer performance indicators Monthly review of cancer performance indicators Ongoing monitoring of patient harm through existing CCG quality governance Oversight of funding for projects associated with Alliance national support fund - There has been communications nationally and locally to patients about ensuring that patients present with suspicious symptoms "NHS is open" campaign - new patient leafest have been shared with primary care to encourage patients to engage with cancer pathways - remote options for initial and follow up appointments have been started at pace-including increase use of teledermandicy; - support cancer pathways cancer urgent surgery historicant throught out there has been enough capacity to ministain what is needed -! If this is concer pathways for surgery ongoing monitoring of patient harm through existing CCG quality governance - mutual aid agreement in place with SWAG Cancer Alliance	4	4	16	(2x5) = 10	+	Cormis sion hg Leadership Team, Commissioning Executive, Quality Gormillee	Into Inter and orbig infinitions and the abovey to continue the cancer work as demand starts to increase with the NEW ACTIONS. There has been communications nationally and locally to patients about ensuring that patients present with suspicious symptoms "NHS is open" campaign. - new patient leaflest have been shared with primary care to encourage patients to engage with cancer pathways. - remain continued to appointments are being used extensively-including increase use of - remain continued to support cancer pathways. - cancer urgent support cancer pathways. - cancer urgent support has continued throughout and there has been enough capacity to maintain what is needed - if this is clinically on the balance of risk recommended for patients. The independent sector capacity has abo been used to support cancer pathways for surgery. - ongoing monitoring of patient harm through easienty CCC quality governance - mutual and agreement in place with SWAG Cancer Atlance Trusts	of by 2021: There are significant risks in the breast pathway (recorded as a separate risk). Lung cancer referrals are all below pre-pandentic levels and therefore there is a need to work with the cancer inequalities group and SWAG to address this issue. A cancer inequality group is focussing on lung as the first project for review how to increase early diagnosis and refers. March 21: No new actions Janifeb 2021: P1 and P2 activity is still prioritised and patients are still prioritised for suspected cancer. Mutual and has been accept as required to support safe and trainey management of cancer patients. The surge plan for EOTC has been activated meaning that additional P2 cancer work for breast, unology and plastics will be protected as the pressures use still an assue. Doc 19 - , final provider outcome status still awaited from NHSE Due Jan 2020			Open	Aug-21	Jul-21
Due to long waits for adult ADHD services in AWP there is a risk to patient experience which may result in the service of the	POS	05.04.19	Lisa Manson	Alex Ward-Bootv Emma Modyl Germa Artz	4 4		A contract performance notice has been issued a joint investigation has started. Key actions include updating booking processes and reviewing the waiting list. The CCG have requested data on the number of patients waiting over 18 weeks so that a review can be undertaten.	4	4	16	(1x1) = 1	+	Clinical Executive Corrmitee	Due to the complexity of resolving this issue, wait times have not reduced over the period that this has been being reviewed. Appear is being presented at Commissioning Exec with a new model that will significantly impact on waiting and improve patient experience. Appear is being as accepted by Commissioning Exec with the cavest that if change was not seen within 12 months, then the CCG would proceed to serve notice. Project group for the new model instigated, with agreed trajectories for improvement being put in place. Recurrent funding for the waiting list approved as part of this new model. Need to establish a flamework for management of requests for assessments by other providers under right to choose	Feb 2021: The LES is being implemented across BNSSG. Current uptake is ca. 20 out of 83 GP practices. The CCC are still awaiting the advised trajectory and the proposals for the resource changes. If anuary 2021: LES is being implemented across all practices where interest has been expressed. CCC are supporting AWP to produce an updated trajectory for the reduction of waiting lists based on their proposed additional resource changes, to be delivered in early! Annuary 2021 - CCG invoked in selficial painties user experience measures to ensure this is inglemented without, negative impact on service user experience. Service specification being developed by AWP for approval in early 2021 by clinical executive, with support of CCG, to establish the future design for the service in response to historical challenges. December 2020: LES is being implemented across all gradicios where interest has been expressed. CCG are supporting AWP by produce an updated trajectory for the reduction of waiting lists based on their proposed additional resource changes, to be delivered on 4th December - CCG invoked in setting service user experience.			Open	Apr-21	Feb.21
As Above Due to AWP having a number of patients placed out of tout (COT) there is a risk in ensuring patients pet tout (COT) there is a risk in ensuring patients pet tout (COT) there is a risk in ensuring patients pet to tout (COT) there is a risk in ensuring patients pet bed base being outside existing contractual obligations there is also a financial risk to the CCG.		As Above 07.05.2019	As Manson Ps As Above	As Above As	Above As Abo		Dose Work streams identified are as follows: - A Mutil Agency Discharge Event on May 16 MADE event showing community realitience the issue. Commissioning meeting 0706 - Introduction of standed process that has been accessful in improving flow in acute hospitals - Report of the introduction of standed process that has been accessful in improving flow in acute hospitals - Ongoing pretricts for determining 0PEL statis. - Ongoing printed from tworking to code and expedite DTOcs - Joining organisational work plans and data diagnostics to create system wide actions - Ongoing observation of acute the dimanagement processes, with community learn to begin - COG Quality learn review of all OTIs on 13.3 19 to review the quality and suitability of placements - Weekly WSOG now up and running Dec 2019: Numbers reduced but pressure still on system		As Above	As Above	(1x1) = 1	As Above	Clinical Executive Committee	As Above	O1 06.21 There has been a recent increase in OAPs in May. A NHSE assurance return has been completed in May, with a deep dive held on the current transformational projects at MH WSCG. AWP held a destbop review in May and are referred in a CAP and the CAP and	As Above	As Above	As Above Open		As Above Jun-21

RefCRR	Risk Description If (cause) then firsk event; resulting in (effect/impact)	Principle Objective ref	entered on register	Risk Lead (exec)	Risk Owner	un mitgate d likeliho od	unmitgated impact	unmitgated risk score risk rating	management actions already in place to mitigate risk (current controls)	current like lihood	current impact	current risk rating	target risk score	movement of current risk score	Oversight Committee	Actions to be taken(as these are completed they should be moved to actions in place)	Comment on progress	w II CCG action alone mitigate risk	Risk appetite	Risk open/closed	target date for completion	last reviewed
Commissioning Directorate: Risk Ref - 24	There is a risk that due to poor data quality at Weston hospital that performance data for all services may not be accurate. This could result in lack of oversight of period ready polymers and time for planned care period planned and purpose and upper care performance and activity.	PO9	06.06.201!	Lisa Manson	Gemma Artz	4	4	16	An information breach notice has been issued CCG are attenting the RTT board CCG are vorking with IST and trust to review and ensure actions in the IST report are followed up Staffing issues in Weston leading by officially in progressing suggested actions from NPSI. Staffing issues in Weston leading to difficulty in progressing suggested actions from NPSI. The trust are yet to share the report with the CCG. There is further financial risk due to previously unknown risk of \$2 week breaches in the trust.	4	4	16	(1x1) = 1	t	Clinical Executive Committee	Staffing issues in Weston leading to difficulty in progressing suggested actions from NHSI. Support is being provided by UHB as not of the due deligence process for RTT in particular. The trust are yet to share the report with the CCG. There is further financial risk due to previously unknown risk of 52 week breaches in the trust.	July 2821: There is an action plan in place within UHBN which has been shared with the CCG and system partners. This will need to be monitored through the planned care system performance group. Jan 2021: Weetion are still in the process of validating their data and seeking support from the IST. Dec 20: Weetion are in the process of validating their data and seeking support from the IST. 12-Nov-2020: Validation of waiting list continues.			Open	Aug-21	Jul-21
ioning Directorate: Risi	RISK SCORE HAS INCREASED AND IS NOW BEPORTED OR RAY As a result of long waits for diagnostic tests and failure to meet the DMO! standard for endoscopy, CT and was not say of potential harm to patients as a result of delayed diagnostics. Which may result in a later diagnosis of their condition and the commencement of appropriate treatment. There is an increased risk of delay in diagnostics due to the Covid pandemic. This is due to a combination of the Covid pandemic. This is due to a combination of miscular delivery due to PPC procedures and avoidance issues and capital space issues.		18.02.202	Lisa	Helena Fuller	4	3	12	There are remedial action plans agreed for UHBVV and NBT. Weation have been issued a contract performance notice and the CCCG awast a remedial action plan. There is additional more; in the system from NHBSE for additional colsocuring and insocuring capacity which has a plan against it which will prevent further deterication and stabilise the position for year end. There is a disposition advisory group as part of the STP long term plan which are focussing on endoscopy. CT and MRD. Capacity and demand planning is ongoing. Reletinals are training and outpriet and 25 www. wast referrals are prioritised. NEW ACTIONS: The diagnostics advisory group are working on how best to use the available capacity to reduce the risk of harm to patients and to make sure that the most valuable diagnostics tests are available. The independent sector will be providing additional capacity to help with the significant backlog that has been created in endoscopy as a result of the Covid risks for the procedure. Routine work has currently stopped, but a plan is to go to clinical cabinet on how best to	4	4	16		t	Clinical Executive Commissioning Leadership	There are workforce issues and space issues related to endoscopy that need to be addressed in the medium and long term which may be a limiting lactor with capacity in the short term economy. The workforce and space issues with endoscopy are exacerbated with the procedures needed for IPC which will significantly reduce efficiency.	July 2021: The fisk remains across all modalities and there is now ongoing work on clinical validation of lists and increased capacity for diagnostics through schemes such as the endoscopy insoutcing and ongoing use of the UK Blobank facility for MRI. June 2021: DMO1 (diagnostic operational standard) - less than 1% of patients should wait 6 weeks or more for a diagnostic test as this was previously unclear, and has been added to the risk discoption. Feb 2021: The biobank additional capacity is now online the ANA projects are ongoing. Endoscopy activity is in line with phase three plans / Further options are being explored to address the backlog.			Open	Aug-21	Jul-21
As Above	As Above As a result of delays in the breast 2WW pathway There is a risk that patients will have later diagnosis of	As Above	As Above	As Above	As Abov	ve As Above	As Above	As Above	Key Actions / Mitigations Skill mixing - 2 consultant radiographers and 3 nurse practitioners i training	As Above	As Above	As Above	As Above	As Above	As Above	As Above Follow up on actions from the regional team - clinical meeting held and regional medical director to convene meeting to make plan.	Current waiting as of 28.05.21.350 patients. Staff working 7 days a week - concerns over how long this can be sustained. No harm has occurred to patients who have been seen	As Above tbc	As Abor	As Abov	As Above	As Above
Commissioning Directorate: Risk Paf - 45	cancer. Which may result in patients coming to harm and requiring more extensive treatment and worse outcomes and psychological distress.	PO1	29/06/202	Peter Brindle	Helena Fuller	5	4	20	National Breast Imaging Academy radiology Millowship scheme – 1 appointee and 2021 applicant pending Locums – 2 consultants providing 2 days per week over International recruitment underway Consideration of a straight to test polithary for +40 pain referrals or the provided of 100% clinical triage of all 2 war referrals or the provided of 100% clinical triage of all 2 war referrals or the provided of 100% clinical triage of all 2 war referrals or the provided of 100% clinical triage of all 2 war referrals or the provided of 100% clinical triage of all 2 war referrals or the provided of 100% clinical triage of all 2 war referrals or the provided of 100% clinical provided of 100% clinic	5	4	20	(2x3) 6	Ť	Clinical Executive Commissioning, Quality Committee, Cancer Programme Board,	interesting to create path.	Section (C. 190 Internal read occurred by passers to write vices occurred.)			uedo	tbc	Jm21
Nurse and Quality: Risk Ref - BNSSGQD021	Patients are at risk of harm from call incident stacking at SWAST causing a delay to ambulance response times	NA	06.12.201	Director of Nursing & Quality	Lead Quality Manager	5	4	20	Ungent care Strategy in place ARE Delivery Board reviews performance on monthly basis Processes in place to manage demand across system including: Daily system esclusion calls Handover SOP in place with acute Trusts NHS-111 Clinate Validation of Clistagery 3 calls NHS-111 Clinate Validation of Clistagery 3 calls AND Clinate Validation of Clistagery 3 calls A Organize deel liston with Dorset CDCs as co-ordinating commissioner 5. Dorset CDC working patient safety data strategy to identify potential harms.	4	4	16	(2x4)=8	+	Quality Committee		Jame 2021: Meeting between DoNs held, and to end pathway reviews ongoing being lad by Lead Commissioner Donat CCCC. Tust are triangulating evidence from Datis, complaints, patient experience data, audit and deep dives into long walls and going forwards Head of Clinical Governance and Patient Safety will SWASFT contract vauilly group. May 2021: Meeting being scheduled between SWASFT DoN and CCG DoN to discuss details of the risk. April 2021: Awaiting data to ascertain the impact of this risk in BNSSG.			Open		Jun-21
D043	If the number of patients with BNSSC contracting MNSA remains alone national benchmarking there is an increased risk in higher mortality rates, poorer outcomes, increased risk lin higher mortality rates, poorer outcomes, increased hospital admissions. Patients have an enhanced risk of potential harm through contracting MRSA Bacteraemia due to the high numbers in the local area.		05.05.202	Director of Nursing & Quality	Lead Quality and HCAI Manager	4	5	20	Commisson pathensity system HCAI group Commisson pathensity acciding and the development of initiathies through the Reast Project. Commisson pathensity backing and the development of initiathies through the Reast Project. Chindradine project roll out and implementation The HCAI Quality Schedule, aligning with the NHS contract, specifies the requirement of contracted providers to screen specific patient cohorts for MRSA and to provide decicionisation treatment where applicable. Opposing review of all monthly cases—pain to review and close all 2018/20 cases. Share findings with system partners through the Quarterly HCAI group to identify farther specific actions to minimise risk striker. Capture and share current provider improvement projects above the system. Commisson pathensity working and the development of initiaties through the Design provinces are to the system. Commisson pathensity working and the development of initiatine through the Design initiative through the Design initiative through the Design in our focal data set. Undertake assurance exercises in line with the HCAI quality schedule. Detailed analysis of individual MRSA cases, with whole system approach pre and post diagnosis. B-Monthly BNSSG Healthcare Acquired Infection meeting with partner organisations to monitor and support MRSA improvements. Replaced MRSA and finish group established. Work organing with the design council to assist with the reduction of MRSA.	3	5	15	(2x5) = 10	+	Quality Committee		suly 2011: Access to UHBMY and NBT records is pending provider approval to enable remote access. Support is being accessed through the CCG Clinical Effectiveness to support the development and sharing of the Chlorhexidine programme. June 2011: Chlorhexidne rollout is now in implementation phase. Evaluation is planned. Project plan being strether developed. May 2001: Remote access to records at UHB and NBT is being sourced to facilitate the review of all community onset cases for 2012. Providers have been eased to provide RCA's for hospital onset cases. Additionally Strona have agreed to contribute to the review where they were involved in the care at or around the time of the incidence. Meeting on 21st April, PHE, Lha and Bristol University who have agreed to support the evaluation. Stristol Locality have confirmed that the wipes are now in use. Year end figures received 31 cases this is down 25% from previous year. Apr 2011: Staged rolloud of Chichesidine begins week commencing 120.421 in the Bristol locality, system rolloud by the end of May 2021. Meeting arranged with localities, PHE and Bristol University to discuss the approach to the evaluation.	đ.		Open	06121	Jul-21
	As a result of COVID 19 and the fact that routine MSK services have been put on hold, there is a risk that switing mes for MSK services will increase which may result in people having to wait, other in pain, for many months to see a Physic or for surgery	POI	28.05.2020	Medical Director	Elizabeth Williams	4	4	16	"The use of the national contract with the Independent Sector to by to restant Ortho surgery and to use the IS Physicia to see patients." *Sanchit Mahendale has agreed to be the clinical lead to implement a single T&O directorate for BNSSG which would enable the most efficient use of resources to nature swaring times. *We plan in bitchode: encre support if the start of the pathway to prevent the need for surgery later on, such as ESCAPE-pain Community based pain management. *We are working closely with the Regional Cetting it Right: Fart Time (GIRFT) seam to learn from other areas to create more capacity within the system to manage the number of people waiting.	4	4	16	(3x3) = 9	Ť	9	have not been able to move forward on the integrated pain service work or the integrated physiotherapy deliverable as the scale and Sirons outpeater physiotherapies are printinging recovery of their waiting lists. LHBM are using recovery funding to employ additional Physiotherapies to reduce the BRI wait time and NET are using their ESCAPE pain course to reduce the reading times. There is a programmer dwork to recover Orthopsedic wait times which includes greater BNSSG working via sub-specialty groups, more transparent whole waiting time information for patients and referrence, better use of the existing capacity and the possibility of creating greater capacity via an elective centre, if additional national recovery funds can be secured.	July 2021: Waiting times are being monitored by the MSK Programme Board and work continues to try and reduce them by implementing self-management apps, providing ESCAPE-pain courses in gyms, health optimisation in public health. The first patient is now being seen on the Orbit appointed Discharge pathways gradient and work is moving on the single patient including list. The six sub-speciality groups are putting or work and work is moving on the single patient including list. The six sub-speciality groups are putting or self-custom sessions to improve integrated working. Jame 2001: We now have 1,550 people who have been waiting over 55 weeks in Orbitopaedics. There are 2 people who are waiting over 16 weeks to see a pain consultar, at have appointments. There are 154 people waiting over 16 weeks to see a Rheumstody Consultar. This is lable of goor as LifeStape and waiting Consultar (apple) who have been validing over 50 weeks in Orbitopaedics. There are 2 people who are waiting over 16 weeks to see a pain consultar, at have appointments. There are 154 people waiting over 16 weeks to a Rheumstody Consultar. This is lable of gornes in LifeStape 3 great and LifeStape Consultar. This is lable of gornes in LifeStape 3 great and LifeStape 3 great and LifeStape 3 great and LifeStape 3 great 3 great 3 great 4 gre			Open	Mar-22	12.00.
As Above	As Above	As Above	As Above	As Above	As Abov	ve As Above	As Above	As Above	As Above	As Above	As Above	As Above	As Above	As Above	As Above	As Above	intal agentheis gloup Water guines are informeduced. Leete to usy do jeouper water gover in weeks so deed an Recumstologist and they at have appointments for the next two months. All urgent physic referrals are being seen within 2	As Above	As Abor	e As Abov	As Above	As Above

Bisk Description If (cause) then (risk event) resulting in (effect/impact)	Principle Objective ref	entere d on register	Risk Lead (exec)	Risk Own er	unmitigated impact	rating	management actions already in place to mitigate risk (current controls)	current like lihood	current impact	current risk rating	target risk score	movement of current risk score	Our riidht Committee	Actions to be taken(at these are completed they should be moved to actions in place)	Comment on progress	wII CCG action alone mitigate risk	Risk appetite	Risk open/closed	target date for completion	last reviewed
As a result of: OCC side take-up of the 2019/20 NHSE Wave-2 IPS funding AwPP agreement to deliver but subsequent non-prioritisation of the service For the COVID-19 cross of the covid of the service For the COVID-19 cross of the Service For the COV	9	27.05.2020	Deborah El-Sayed	Victoria Biesz and	4 3	12	01 04 2021 - Discussions orgoing with Mirt contracting learn on approach and possible finances. Expected immentely. 08.03 2021 - IPS now live & taking refernals & working to support. Business case developed to repurpose existing employment support going through system currently which may resolve this. 08.02 2021 Richmond fellowship staff now appointed, AWP manager is out to advert. Risk re: coverage still live due to funding decision which is still asselted. 13.01 2021 - AWP leading the implementation with Richmond Fellowship. New trajectory proposed for recruitment of staff, taking referrals and people starting paid work from Feb 2021 to June 21. Risks: The new service will not provide full BNSSG coverage (in the Bristink Recovery service) without further interestment in 2122 as existing IPS capacity across BNSSG has reduced from 2.4WTE to 1WTE since the Wave 2 bid and LTP plans were submitted.	5	3	15	(2:3) = 6		il Executive	May 21 - Current Richmond J BMH employment service moving toward total IPS model from Sep 21, to be integrated with the new IPS service - to form one single IOS service offer. This will provide a consistent offer over all MH Team types in BNSSG. AWP IPS manager in place. AWP IPS manager in place. The NHSE expectation is for a steep trajectory of CCG investment in IPS over the next five years. BNSSG has to budgeted south investment in for this and it remains at the 21/22 (lower than required) level. Business case in development to address	June 21 - No change 01.04.2021 - Discussions ongoing with MH contracting feam on approach and possible finances. Expected immerities immerities to the activities of the station referrals & working to support. Business case developed to repurpose aciding employment support going through system currently which may resolve this. 08.02.2021 Richmond fellowship staff now appointed. AWP manager is out to advert. Risk re: coverage still live due to funding decision which is still awaited.			Open	Sep-21	Jun-21
As a result of COVID19, there is a risk that delivery of the Long Term Plan deliverables and goels will not be a considered, and impacts cannot be measured, which may result in increasing delays, poor experience and poor value care.		22.05.2020	Evelyn Barker (Planned Care) and Peter Brindle (Cancer)	Andy Newton	5 3	15	July 21- BSSS is astill working hard to achieve 120% of activity by the end of July 2021. Plans are being implemented at speed. June 21 - BNSSG has become a national Accelerator site and is working to try and achieve 120% of activity (by value) by the end of July 2021. Commands are structures are in piace and plans are being implemented at speed. May 21 - MSK. Outpatients, Diagnostics and Cancer Programmes all in place focusing on recovery. March 21 - 21/22 planning is focused on elective care recovery. Embedding transformation of elective care services will be certain to development of 21/22 plans. For planned care, this will include recovery of routine care in line with planned care where possible, services should be recovered in ways which further the objectives of the long term plan. Where this is not possible, plans about be revised and upstant for reflect the unavoidable service changes. Phase all access plan included investment in additional capacity across planned care specialise and diagnostics for recovery to near pre-COVID activity levels Planning for 21/22 will now include capacity and certains work to reduce the backing. The planned care board has established work, programme to deliver the high level principles.	5	3	15	(3x4) = 12	.	System Change Command, Planned Care Board, Can oer Board and Cancer Cell, Diagnostic and Outp BNSSG CCG Quality Committee BNSSG Clin Executive	July 21 - Accelerator work continuing to be implemented to increase activity and reduce length of stay. The first patient will use the Orthopseedic Supported Discharge pathway on the 41th of July. June 21 - Accelerator Command and Control system is in place to manage the work to reach 120% activity value by July 2021. Lots of projects being implemented to increase capacity, such as weekend and evening working, supported discharge, using list validation. Patient Initiated Follow Upe etc. May 21 - Elective Care Recovery Command and Control systems being set up to manage the work to reach 120% activity value by July 2021. Lots of projects will be put in place to increase capacity, such as weekend and evening working, value light self-activities and evening working, vasting sits validation, Patient Initated Follow Upe etc. The impact of some of the unsocidable service changes is not yet known (for exemples, capacity constraints The impact of some of the unsocidable service changes is not yet known (for exemples, capacity constraints). The patient of some of the unsocidable service changes is not yet known (for exemples, capacity constraints). The impact of some of the unsocidable service changes is not yet known (for exemples, capacity constraints). The impact of some of the unsocidable service changes is not yet known (for exemples, capacity constraints).				Open	Jul-21	Jul-21
As a result of patients not presenting to services early There is a risk that patients will present at a later stage of canicor Which may result in patients requiring more extensive transcent and patients will not be given the best chance of survival Log Term Plan Legal ** 75% of cancers are diagnoses of the control o	P01	04.02.20.21	Peter Brindle	Andy Newton	4 4	16	This risk has been transferred from the Cancer Programme Board risk register: A CCG plan will need to developed in collaboration with the Cancer Alliance and the STP Acute Care Collaboration steering group in order to deliver priorities for cancer identified in the long term plan. Targeted communications / national media campaigns to highlight need to present to their GP early.	4	4	16	(3x4) = 12	+	BNSSG STP Cancer Programme Board Quality Committee BNSSG Clinical Executive	June 21 - Helsens Fulfer and Rachel Anthwell are providing support to Margaret Kemp while Andy Newton is of stick.	July 21 - Paper sent to Helena Fuller recommending direct aware to C the Signs with mitigation against a legal challenge including a 30 days stand still period after publication of award. CCG support for Prostate Cancer UK. Men's Health Week campaign 14 - 20th June and the Roy Castle Lung Foundation Spot the Difference campaign stands of the Commence campaign and the Standard Section of Commence and Cancer Section of Commence of the Commence of C			uedO	2028	Jul-21
As a result of the Covid-19 pandemic There is a risk of increasing health nequalities in patients with cancer of at risk if cancer because of potential differences in delayed diagnosis Which may result in poser outcomes access different population groups 20 Our understanding of this risk is still developing as local and national data is gathered and analysed 20 Our understanding of this risk is still developing as local and national data is gathered and analysed 21 Our understanding of this risk is still developing as local and national data is gathered and analysed	POI		Peter Brindle	Andy Newson	4 4	16	 A review of the data is required to understand the current situation and expand on the risk and identify mitigating actions. Work is undernay using the PHM data set to target work on specific populations where adverse outcome is most likely—current focus on lung referrals 	4	4	16	(3x4) = 12	+	ACC Cinical Executive Quality Committee	Improved information required on cancer outcomes and performance by different population groups	July 21 - Meeting held on the 17th June. Further work has been undertaken on the reverse care pathway following ame medium with clinicals more UHBW and NRT. Key questions and comparator propryal identify which will now be used to integrate the System Wide data set. Inequalities in terms of access I take up of smoking cossion also to be looked at and prescribing data by practice. Intitla SWAG meeting held on the 23rd June to discuss the Alliance wide approach to Target Health Lung Checks (THLC). June 21 - Meeting held on the 20th May, Lewis Peake to arrange meeting with identified clinical staff from UHBW and NST to gain understanding of the reverse pathway for lung cancer and to identified clinical staff from UHBW and NST to gain understanding of the reverse pathway for lung cancer and to identified clinical staff show the UHBW. NST and primary care to identified where the inequalities exist and not taper! Jarget and an eneting with first public health collegates to discuss the reverse pathway approach to lung cancer on the 27th April in terms of the lung cancer health inequality it was greed that clinical input was needed and the Cancer Lead rauses at LHBW and NST are exploring who can support this work. If has been suggested that there is a case for a SWAG wide approach targeting prockets of high prevalence. 31.03.21 First meeting of BNSSG cancer inequalities group held on the 4th March of SC 221 Targeted communications have been developed as part of a wider communications plan encouraging			Open	Mar-22	12:100
UEC Programme - If there is insufficient community urgent care capacity across BNSSG, the NHS 111 First Standard Community urgent care capacity across BNSSG, the NHS 111 First Standard Community urgent care capacity across BNSSG, the NHS 111 First Standard Community urgent care capacity across BNSSG, the NHS 111 First Standard Community urgent care capacity across BNSSG, the NHS 111 First Standard Community urgent care capacity across BNSSG, the NHS 111 First Standard Community urgent care capacity across BNSSG, the NHS 111 First Standard Community urgent care capacity across BNSSG, the NHS 111 First Standard Community urgent care capacity across BNSSG, the NHS 111 First Standard Community urgent care capacity across BNSSG, the NHS 111 First Standard Community urgent care capacity across BNSSG, the NHS 111 First Standard Community urgent care capacity across BNSSG, the NHS 111 First Standard Community urgent care capacity across BNSSG, the NHS 111 First Standard Community urgent care capacity across BNSSG, the NHS 111 First Standard Community urgent care capacity across BNSSG, the NHS 111 First Standard Community urgent care capacity across BNSSG, the NHS 111 First Standard Community urgent care capacity across BNSSG, the NHS 111 First Standard Community urgent care capacity across BNSSG, the NHS 111 First Standard Community urgent care capacity across BNSSG, the NHS 111 First Standard Community urgent care capacity across BNSSG, the NHS 111 First Standard Community urgent care capacity across BNSSG, the NHS 111 First Standard Community urgent care capacity across BNSSG, the NHS 111 First Standard Community urgent care capacity across BNSSG, the NHS 111 First Standard Community urgent care capacity across BNSSG, the NHS 111 First Standard Community urgent care capacity across BNSSG, the NHS 111 First Standard Community urgent care capacity across BNSSG, the NHS 111 First Standard Community urgent care capacity across BNSSG, the NHS 111 First Standard Community urgent care capacity across BNSSG, the NHS 111 Firs	PO9	06.05.21	Lisa Manson	Kate Lavington	4 4	16	Key areas of risk (MIUUTC capacity) being managed through contract route by commissioning team.	1	4	4	(2x4) = 8	1	Clinical Executive	UCSG agreed (5527) to establish a programme of work fed by COG and 111 Clinical Leads Group to review the front door model and required capseity and make recommendations about adjustments needed to ensure the right capacity is in the right place in time for winter.	Additional funding agreed for Sirona to increase capacity for 2021/22 whilst broader changes to UEC			Open	Jun-21	Jun-21
B USC Programme - ED booking for NHS 111 is contently withched oil in RNSS due to walk in activity to pressures. This results in the BNSSG system being no complant with a national requirement and associated reputational risk.	PO9	06.05.21	Deborah El-Sayed	Kale Lavington	4 4	16	SBAR agreed summarising the position in BNSG. Regular reviews with ED clinical and managerial leads during April. NHSEI key informed at all ratega. Clinical consensus is unanimous that the setsly risks of wishling on the slots outweigh the potential benefits for the system. 111 First Programme Group endorsed this on 30/4/21. UCSG briefed 5/5/21.	4	4	16	(2x2) = 4	↔	Clinical Executive	on as quickly as possible.	Progress being made. Additional investment agreed for Sirona. minor injuries SDP reinstated. System CSAS development being accelerated for prelicate southerned souscessful pilotic hustiness case for use of non recurrent monies developed which, if approved, should enable ED booking to be switched back on as a result of increased system confidence in 111 outcomes. Progress being made - minor injuries SOP being reinstated and system CAS development being accelerated.			Open	Aug-21	Jul-21
If we do not have a clear, agreed work plan in place there is a risk that the volume dwork will not be sustainable for the team. This could result in not being a clear that the sustainable for the team. This could result in not being a clear that the sustainable for the team. This could result in not being a clear that the sustainable for the s	PO8	10.06.21	Deborah El-Sayed	Michelle Smith, Rebecca Murch and Alex Ward Booth	5 4	20	Priorities plain is in place, this is regularly reviewed at the senior leadership meetings. This has been shared with the Exec lead and they are sighted and aware of pressures and the plans in place to manage those.	4	4	16	(3x3) = 9	+	Senior Leaderahip team , Skategio Finance Corrmitee	Continue to review the priorities plan at the weekly senior leadership feam meeting and update accordingly. Update Exec Lead on any changes or emerging pressures as things change.	Senior lawdership feare continue to review workplan on a weekly basis to ensure that projects are progressing and regularly identifying where work needs to be paused or additional resource is required.			Open	Apr-22	Jun-21

Risk Description If (cause) then (risk event) resulting in (effect/impact)	Principle Objective ref	entered on register	Risk Lead (exec)	Risk Owner	un mitgate d likeliho od	unmitigated impact	unmitgated risk score risk rating	management actions already in place to militigate risk (current controls)	current like lihood	current impact	current risk rating	target risk score	movement of current risk score	Oversight Committee	Actions to be taken/as these are completed they should be moved to actions in place) Comment on progress Actions to be taken/as these are completed they should be moved to actions in place) Comment on progress Actions to be taken/as these are completed they should be moved to actions in place)
If we do not have allocated comms support for the transition of staff to the CSD there is a risk of employee the transition of staff to the CSD there is a risk of comployee disengagement and a lack of workforce preparedness, and the staff of the compared the compared the compared to the compared the compared to the c	POS	10.05.21	Sarah Truelove	Michelle Smith	5	4	20	Meeting with Starta Trustove to discuss resource requirements and capacity in the team within the current staffing model to support the transition communication programme of work.	4	4	16	(2x2) = 4	+	Senior Leadership team , Strategic Finance Committee	Scoping and deterfibing the resource that would be required for internal communications support to ensure a successful transition to ICS. Ensuring that staff are engaged in the process and supported in the new organisation. Scoping and deterfibing the resource that would be required for internal communications support to ensure a supported in the new organisation. Scoping and deterfibing the resource that would be required for internal communications support to ensure a splan evolve and we hear move about key transition to ICS. Ensuring that staff are engaged in the process and supported in the new organisation. Comms to scope additional support that may be required based on exiting workforce and capacity.
RISK SCORE HAS INCREASED AND IS NOW REPORTED ON CRR There is a current resource gap with a number of planned and unplanned absence sacross internal, external and insights teams. These gaps are important of the control of the contr	P08	09.07.21	Deborah El-Sayed	Michelle Smith	5	4	20	Have secured funding to recruit temporary agency resource to support during the summer.	5	4	20	(2x2) = 4	New Risi	Senior Leadership team	Review the team work plan and deliverables and assess if targets are realistic and if this will have any impact on hard deadlines. Leg of the plant
RISK SCORE HAS INCREASED AND IS NOW REPORTED ON CRR Due us not being able to secure a secondment extension for the Internal communications with the secure of the secure	POS	09.07.21	Deborah El-Sayed	Michelle Smith	5	4	26	This will be disucssed at the People Plan Steering group.	5	4	20	(2x1) = 2	New Risi	Se nor Le adership team	Review work plan alongside resource and review gaps and what can be paused. Contact agency support to try and get additional support into the team. 157 PD 17 PD 187 PD 187 PD 187 PD 187 PD 188 PD 1



BNSSG CCGs Governing Body Assurance Framework 2021-22 (July 2021 V1)

Governing Body Assurance Framework risk tracker

The Governing Body Assurance Framework identifies the BNSSG CCGs' principal, strategic objectives and the principal risks to their delivery. Controls in place to manage those identified risks are summarised. The internal and external assurances that controls are in place and have the impact intended are set out. Where there are gaps in controls or assurances these are described and the actions planned to mitigate these gaps are explained. The table below gives an overall summary of the Governing Body Assurance Framework. The detailed framework is at page 4

Risk Tracker	Lead Director	Initial Risk	Current risk	Target risk	Trend
		score	score		
Principal Objective PO1:	Committees: G	overning Bo	ody, Prima	ry Care	
COVID 19 This risk relates to the delivery of all objectives reported on the	Commissioning	Committee,	Strategic	Finance	
Governing Body Assurance Framework	Committee, Qua	ality Commit	tee		
Principal Risk: As a result of the impact of Covid-19 there is a risk that the need to	Julia Ross/	5x5= 25	2x5=10	2x4 =8	
focus capacity to meet the demands on the system may result in the system and the	Sarah				
CCG not delivering the objectives identified in the Governing Body Assurance	Truelove				
Framework					
Principal Objective PO2:	Committees: H	ealthier Tog	gether Part	nership Bo	oard
Integrated Care Systems: Making the transition from STP towards a mature ICS	Governing Body	, Strategic l	Finance Co	mmittee	
that takes collective accountability and delivers our system aims.					
Principal Risk: As a result of the White Paper there is a risk that the progress we had	Julia Ross/	4x4= 16	3x4	2x4=8	
been making on becoming a mature ICS falters due to the distraction caused by the	Sarah		=12		
change in organisational form which may result in the system not delivering the	Truelove				
recovery objectives agreed.					
Principal Objective PO3: Integrated Care Partnerships:	Committees: G				
To deliver personalised preventive and proactive care at a locality and	Commissioning				
neighbourhood level. By April 2022 core services will be delivered by Integrated	Committee, Hea				
Care Partnerships. This will be underpinned by population health and value	(external), Integ				
based principles to reduce variation, tackle health inequalities and ensure high	Integrated Care	Partnership	s Oversigh	nt Group (s	system
quality care for all	wide)				

Principal Risk: The complexity and extent of the change required to set up integrated care partnerships that are capable of holding core service contracts is significant. There is a delivery risk that this opportunity will not be fully realised before the April 2022 deadline.	Deborah El- Sayed	4x4= 16	3x4=12	2x4=8	
Principal Objective PO4:Mental Health To be able to respond to the Mental Health needs population, preventing crisis and promoting wellbeing	Committees: C Strategic Financ Oversight Board	e Committe	e, PPIF, S	ystem - Mł	1
Principal Risk: As a result of COVID 19 there is a risk that demand for MH services will increase by which may result in a poorer access and outcomes for people, increased level of Mental Health crisis and further spend on aspects of services like out of area placements and S117	Deborah El-Sayed	5x4= 20	4x4= 16	3x4 =12	
Principal Objective PO5: Learning Disability and Autism: Improving outcomes and reducing health inequalities for people with learning disabilities, people with autism and those who have both, within BNSSG	Committees: Q	uality Comn	nittee		
Principal Risk: As a result of a lack of integrated services there is a risk that we reduce the life choices for individuals with learning disabilities and autism which may result in widening of health inequalities and the health of the population in the future	Rosi Shepherd	4x4= 16	4x4= 16	3x3 =9	
Principal Objective PO6: Children's Services: To improve the commissioning of services for children	Committees: C and Strategic Fi			ity Commit	tee
Principal Risk: Integrated children's commissioning with Local Authorities is not fully developed, there is a risk that we are not optimising the care children receive and impacting on their life course	Lisa Manson	4x4= 16	3x4 =12	2x4=8	
Principal Objective PO7: Funded Care: Delivery of an integrated, efficient, Funded Care service achieving the "leading" level of the CHC Maturity Framework with high levels of positive patient experience and staff satisfaction	Committees: G Committee, Qua			gic Finance	9
Principal Risk: There is a risk that capacity and demand in the CHC service are not aligned, due to increased demand, complexity of cases and capacity and process issues within the team. This has the potential to result in delayed access to the right care for patients, financial pressures for the CCG and non-compliance against national framework standards.	Rosi Shepherd	3x4=12	3x4=12	2x4 = 8	

Principal Objective PO8: People Plan Developing the CCG's People Plan	Committees: G	overning Bo	ody, Strate	egic Finance	Э
Principal Risk: There is a risk that the progress made in developing the culture and staff experience within the CCG may be disrupted and lost as we transition to becoming an ICS resulting in falling staff satisfaction and increased turnover.	Dave Jarrett Sarah Truelove Julia Ross	4x4= 16	3x4=12	2x4 = 8	
Principal Objective PO9: Financial Sustainability: Deliver financial sustainability and improved health outcomes through the use of population health management and a culture of systematically evaluating the value of our services to our population.	Committees: S Body, Clinical E Delivery Oversig	xecutive, Cl		•	_
Principal Risk: As a result of the current culture driven by Payment by Results there is a risk that there will be a continuing focus on activity rather than value which may result in failure to deliver improved population health and financial sustainability for the CCG and the system.	Sarah Truelove Peter Brindle	5x4= 20	4x4= 16	2x4 =8	

The CCG risk scoring matrix as set out in the Risk Management Framework is:

Risk Assessment scoring matrix

ning	Almost certain = 5	5	10	15	20	25
appe	likely = 4	4	8	12	16	20
d of h	possible = 3	3	6	9	12	15
likelihood of happening	unlikely = 2	2	4	6	8	10
like	Rare = 1	1	2	3	4	5
		Insignificant = 1	Minor = 2 Impa	Moderate = 3 ct	Major = 4	Catastrophic = 5

Governing Body Assurance Framework

objectives r Framework	eported on	sk relates to the de the Governing Boo	dy Assurance	Director Lead: Julia Ross/Sarah Truelove						
need to focus	s capacity to system and t	npact of Covid-19 th meet the demands on the CCG not delivering Body Assurance F	ng the objectives	Date Last Reviewed: 18/06/21						
Initial Current Target risk	Likelihood x impact 5x5=25 2x5=10 2x4=8	Risk Appetite	Risk Score Trend	Rationale for current score: The changes that have been made to the ICC mean that a dedicated team have now taken on the management of the incident allowing the remaining management capacity to focus on other CCG priorities. This has reduced the likelihood to 2.						
Controls: (W Vaccine progr Outbreak mar manage case Data group m can get notice more proactiv ICC resource ICC in place f escalate issue H1 plans deve and capacity i goals. Financial reso Agreement ac Surge plan in Further plan of Mitigating Ac and close any	dy, Primary Comittee, Quality hat are we cure amme hagement plant is of COVID at eeting weekly of changing e response. The system is and the system is in place to extreme and testions: (what it identified gaptical extreme and testions).	care Commissioning Committee Internally doing about the Ins in place in each of and minimise the spread to review the UoB malevels of the disease in the eep to a minimum to each oversee the response when represent the services are organisms are progress can be to support this response to the priorities in the during second was all enacted with leaders further actions are ne	is risk?) the three LA areas to ad. odel to ensure services of our system to enable a deal with the response. Inse with ability to needed. Insed to mitigate risks of made on system onse. Ithe H1 response. Ithe H2 response. Ithe H1 response. Ithe H2 response. Ithe H3 response. Ithe H2 response. Ithe H3 response. Ithe H4 response. Ithe H3 response resp	Rationale for target risk: The target risk aimed to reduce the impact of this risk, the current approach has reduced the likelihood of this risk occurring but not the impact currently. Assurances: Governing Body receives regular updates on recovery including information on: Number of cases in our population compared to the national picture Actual activity against our local model to give confidence in the future predictions Phase 3 plans are being delivered or exceeded in most cases NHSE/I provided positive feedback at surge meeting of management of COVID escalation within BNSSG GB can see progress being made on other areas of business within the CCG. Gaps in Assurance: (What additional assurances should we seek?)						

(PO2) Objective: Integrated Care Systems: Making the transition from STP towards a mature ICS that takes collective accountability and delivers our system aims.				Director Lead: Julia Ross/Sarah Truelove
had been ma caused by the	king on become change in or			Date Last Reviewed: 12/06/21
Risk Rating		Risk Appetite	Risk Score Trend	Rationale for current score:
Initial	x impact 4X4 =16			The partnership Board recently gave commitment to development of the ICS development plan and the survey carried out demonstrated a high
Current	2x4=8			level of shared commitment. An initial development session for the MOU
Target risk	2x4=8			confirmed significant alignment on the vision for the ICS across the executive group.
. engarrien				The level of ambiguity nationally could drive a misalignment of expectation about the way system working which could destabilise the partnership.
Committee with oversight of risk Healthier Together Partnership Board, Governing Body, Strategic Finance Committee				Rationale for target risk: If we are unable to reduce the likelihood, then in the long term the lack of system focus will have a material impact on our ability to achieve a sustainable system that meets the needs of the population. It also risks reversing all progress we have made in improving the reputation of BNSSG and reduce the credibility of the CCG as a system leader.
•		rrently doing about th	•	Assurances:
	•	ard and Executive Gro Group in place week	• •	 Long Term Plan agreed with NHSE/I BNSSG recognised as an ICS
engagem	ent across the	system.		Phase 3 plan accepted by NHSE/I
Regular re and Trans	eporting to the formation	·	Performance, Finance	 NHSE/I November Board paper 'Integrating care: Next steps to building strong and effective Integrated Care Systems in England' set clear intent for system working
Reporting of the system financial position to SFC				Inclusion in the Queen's Speech the intention to bring legislation to establish a statutory ICS

- System Performance and Oversight is managing the implementation of the phase 3 plan, with performance reporting in place fortnightly.
- Clear plan coming together to enable the MOU and supporting work streams to be agreed by the Partnership Board in July 2021.
- Interim Chair in place until September 2021.
- Running a second and third wave of the system leadership programme (Peloton)

Mitigating Actions: (what further actions are needed to reduce the risk and close any identified gaps)

- Facilitating a process of co-production for our ICS development plan, MOU, Performance management framework, financial management framework, OD plan, Quality and improvement framework, outcomes framework and Comms and engagement strategy.
- Recruiting to an enhanced role for an independent Chair. To be in place by October (but this is subject to National guidance)

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

• Formal delegation to Partnership Board enshrined in a Memorandum of Understanding or similar.

Director Lead: Deborah El-Sayed

Risk: The complexity and extent of the change required to set up integrated care partnerships that are capable of holding core service contracts is significant. There is a delivery risk that this opportunity will not be fully realised before the April 2022 deadline.

NB: This deadline is critical given the national policy direction, the need to transition community MH services and the importance of delivering integrated care for the population

Risk Score Trend

Date Last Reviewed: 21/05/21

integrated car	alation	
Risk Rating	Likelihood	Risk Appetit
	x impact	
Initial	4X4 =16	
Current	3x4=12	
Target risk	2x4=8	

Rationale for current score:

We have co-produced the discovery products with the system and significant number of engagement events and discussion sessions have been conducted. There is significant support from all system partners.

Key decisions such as the footprints for ICPs have been agreed by Healthier Together Partnership Board. The ICP discovery programme will complete an end stage report summarising learning and developments to Healthier Together Executive Group on 3rd June. The report summarise the tangible decisions required in the design phase of ICPs and how learning will be applied.

A programme of enabling work streams has been established to create the conditions required to support ICPs to be successful. The programme will bring grip to manage the critical path between now and April 2022, escalating risks and issues for resolution.

Whilst partners are well engaged and enthusiastic about developing ICPs, two key risks have been highlighted: (a) the pace and timeframe to be ready to take on community mental health from April 2022 and the capacity available; (b) more detail is required on the financial envelope and resources available to support

Committee with oversight of risk

Governing Body, PCCC, SFC, Healthier Together Partnership Board (external), Integrated Care Steering Group (ICSG external), Integrated Care Partnerships Oversight Group (system wide)

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

- A continued programme of work to prepare Primary Care Networks (PCNs) and localities to sit at the heart of ICPs.
- Continued organisation development (OD) programmes for locality partners and PCNs and system wide (PCN and locality in progress system wide to initiate in January 2021).
- A programme of work to explore and develop options around the infrastructure and enablers required to build ICPs (FAQs and engagement in scope here) – the discovery programme
- A monthly communication to all partners setting out learning, observations and conclusions drawn from the discovery oversight group.
- CCG Clinical Leadership review refocuses localities as collective of PCNs
- Community Mental Health Framework sufficiently developed to enable focussed development and engagement
- Detailed planning and inter dependency mapping for all ICP workstreams

Mitigating Actions: (what further actions are needed to reduce the risk and close any identified gaps)

- Consideration of the local and ICS-wide governance arrangements that will enable ICPs.
- ICP reporting to be developed for PCCC
- ICP maturity framework has been co-produced and is being developed with locality and system partners to ensure it reflects the pathway and supports delivery actions that localities are keen to get on with
- Developing model of care through system wide co-production events has concluded a draft that will now be developed further by a Clinical and Professional reference group (ToR being drawn up)
- Learning Connections now established with Alaska, Christchurch New Zealand, Greater Manchester LCOs. Currently drawing up dates for webinars through late March and April as part of the OD programme
- Learning partnerships are being drawn up with other systems to

Rationale for target risk:

Through good governance, engagement and communications it is proposed these risks can be mitigated as the control workflows begin to deliver

Assurances:

- Internal Assurance provided through Primary Care locality/PCN maturity matrix reporting to PCCC
- Internal assurance reporting on key performance milestones to ICP Oversight Board and to Governing Body
- Internal Audit Locality Collaboration and Governance (June 2021)
- Internal Audit Delegated Commissioning (June 2021)

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

- support pace, learning and an evolving adapt and adopt model.
- Presentation to HT Partnership Board March 11th (footprints decision point)
- Developing Partnership Agreements: HT Exec ICP development session 26th March - subsequent session to be planning for April (CMH ICP Partners: Partnership agreement Working Session followed by a Wider stakeholders working session)

(PO4) Objective: To be able to respond to the Mental Health needs population, preventing crisis and promoting wellbeing Risk: As a result of COVID 19 there is a risk that demand for MH services will increase which may result in a poorer access and outcomes for people, increased level of MH crisis and further spend on aspects of services like out of area placements and S117				Director Lead: Deborah El-Sayed Date Last Reviewed: 21/05/21	
Target risk	3x4=12				
Committee with oversight of risk Clinical Executive, Quality Committee, strategic Finance Committee, PPIF, System - MH Oversight Board linked to Health and Wellbeing boards Controls: (What are we currently doing about this risk?)			ealth and Wellbeing his risk?)	Rationale for target risk: The workforce challenges in mental health services means there is not an easy solution to increasing capacity within the services and therefore it is felt unlikely we will be able to reduce the likelihood below 3 during this year. Assurances: Whole System Operational Group	
 New investment has been identified through spending review (e.g. IAPT, IPS, physical health checks for SMI, EIP). Target Operating Model for integrated community mental health service being finalised. LTP objectives/ Business Case benefits are being monitored via delivery assurance processes 			EIP). nunity mental health	 Finance Overview Group (system-wide) Improved access and reduction in waiting time / lists for services Reductions in OOA placements and S 117 Lived experience feedback and surveys Internal Audit Out of Area Placements (Dec 2020) 	
dashboard		ng reinstated into W	ystem via system wide SOG / POG forums and	Programme portfolio delivery impact reports	
 H1 planning has reset the key deliverables and expectations for achievement this will be monitored as part of POG 				Gaps in Assurance: (What additional assurances should we seek?)	
 Performance is being monitored via a range of committees as detailed above. 					
 MH ED task and finish group has been established to address the crisis pathway and the impacts of COVID on capacity in the systems— The MH ED programme has now driven a series of improvements from Street Triage increases to additional Sanctuary service in Gloucester house providing an alternative to ED for people in MH distress 					

 New steering groups for Community MH services are now in place these are co-chaired by experts by experience

Mitigating Actions: (what further actions are needed to reduce the risk and close any identified gaps)

- Each of the MH programme portfolio projects are designed as mitigation actions for specific components linked to addressing the impact of the nature of the demand increases. Specific list available on request
- Each programme has a clear delivery impact and evaluation plan to ensure that we can be assured of the efficacy of the mitigation
- Need further insight into patient experience seeking patient experience measures to be factored into commissioning processes
- MH services available via 111 first are now increasing to include the sanctuary service, and a connected approach to telephone support
- MH services have now been profiled onto MiDOS to ensure that GPs and other referring parties are able to access the full extent of system wide services
- The elemental social prescribing platform will be available in Feb 2021 this will enable direct access to MH and wellbeing support services
- IPS service is now live and taking referrals
- NHS Benchmarking project has commenced and will help support measurement

(PO5) Objective: Learning Disability and Autism: Improving outcomes and reducing health inequalities for people with learning disabilities, people with autism and those who have both, within BNSSG				Director Lead: Rosi Shepherd	
reduce the lif autism which	e choices for i	ndividuals with learni widening of health inc	there is a risk that we ng disabilities and equalities and the health	Date Last Reviewed: 16/06/21	
	Likelihood x impact	Risk Appetite	Risk Score Trend	 Rationale for current score: Goal of 67% of people with learning disabilities receiving Annual Health 	
Initial	4X4 =16			Checks and Health Action Plans has been achieved (69%).	
Current	4x4=16			Number of people within the Transforming Care Programme place out of area remains above trajectory.	
Target risk	3x3=9			Robust approaches to ensure assurances regarding the quality of commissioned individual care packages in development.	
				 Approaches to ensure implementation of learning from LeDeR reviews in development. 	
				Identified need to increase levels of engagement and inclusion of people with Learning Disability and/or Autism, parents and carers and people from BAME community with of Learning Disability and Autism (LD&A) issues	
Committee v	vith oversigh	t of risk		Rationale for target risk:	
Quality Com	mittee			The target risk score reflects the long term nature of this programme of activity to reduce the risk	
		rrently doing about th		Assurances:	
		earning Disability and		The sources of assurances available relating to this objective are	
		wide membership, su	pported by Learning	Internal assurance provided through regular reporting of performance This is a stress of a s	
•	and Autism S		lan is regularly monitored	against key performance indicators and progress of action plans to Quality Committee, Learning Disabilities and Autism Programme Board	
	CG LD&A de		ian is regularly monitored	and Governing Body	
•		eports to committees a	and governing body	Internal assurance provided through regular reporting on LeDeR to	
		insforming Care perfo		LeDeR Steering Group, Quality Committee and Governing Body	
			ult Autism Assessment	LeDeR Internal Audit Report Feb 2020	
		Educational Needs and		CQC/Ofsted Joint Inspection Reports and written statements of action Assuring Transforming Core Programme as best reporting to NUICE and	
Annual Health Check and Health Action Plan delivery (Target 67% by end of Q4)				 Assuring Transforming Care Programme cohort reporting to NHSE and Learning Disability and Autism_Programme Board 	
 Learning Disabilities Mortality Review (LeDeR) Steering Group and 				Comprehensive Quality Assurance processes relating to individual CCG	
review process established with representation from across all				commissioned placements for people with Learning Disability and Autism	
providers, primary care, social care and NHSE regional leads				is in place through full implementation of commissioner oversight visits	

- LeDeR process includes Clinical Case Review to identify all learning
- LeDeR Service User Forum established
- Mechanisms to support integrated Education, Health and Care (EHC) needs assessment process in place
- All contracts with providers include a learning disability schedule with Improvement Standards monitored through agreed IQPM processes
- Business case completed outlining requirements to increase capacity within the CCG to complete Care (Education) and Treatment reviews and Quality Oversight visits in line with NHSE policy and guidance
- EIA of TCP and CHC cohort of people with LD&A completed to be shared at Quality Committee in July 2021
- Funding secured to implement pilot project to facilitate discharge of long stay individuals from locked rehabilitation placements

Mitigating Actions: (what further actions are needed to reduce the risk and close any identified gaps)

- 3 year BNSSG LD&A Delivery Plan is in development (to be signed off by CCG and Healthier Together in June)
- Development of agreed SOP Protocol for C(E)TR processes, including Dynamic Support Register and thematic evaluation (end Q2)
- EIA of TCP and CHC cohort of people with LD&A (end Q1)
- Development of LeDeR actions with specific themes to develop provider action plans (end Q4)
- Hosting learning events to raise awareness and share good practice
- Continued implementation of the Adult Autism Assessment Waiting List Initiative
- Training and wider support for Primary Care to improve annual health check uptake and increase the numbers of Health Action Plans. Undertake evaluation of HAP delivery.
- Identification of lessons learnt from disproportionate impact of COVID 19 on people with LD&A and implications for other areas of inequality, e.g. cancer screening / flu immunisation
- Establish mechanisms for the inclusion of people with LD&A and parent / relatives of people with experience of supporting a person with LD&A in service development
- SEND action plans in place with local authority partners
- CCG Strategic SEND lead also taking lead for C&YP LD&A programme aligned and working in tandem with adults LD&A programme lead to strengthen capacity.

and Learning Disability and Autism Host Commissioner function.

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

 BAME representation with specific experience of learning disability and autism issues on programme board, LD cells, operational working groups and LeDeR Steering Group to ensure the additional health inequalities experienced by BAME communities and people with learning disabilities are addressed in all workstreams.

•	Business case to be completed for discharge facilitation project (by end July 2021)	

(PO6) Objective: To improve the commissioning of services for children				Director Lead: Lisa Manson	
fully develope	d, there is a r		ocal Authorities is not timising the care children	Date Last Reviewed: 21/05/21	
Risk Rating Initial Current Target risk	x impact 4X4 = 16 3x4=12 2x4=8	Risk Appetite	Risk Score Trend	Rationale for current score: Current commissioning arrangements do not put children at the centre of decision making which can impact on the outcomes, due to fragmented decision making.	
Committee w Clinical Execu			gic Finance Committee	Rationale for target risk: The intention is by developing integrated children's commissioning the outcomes for children will be optimised and the likelihood of the risk occurring will be reduced.	
 Controls: (What are we currently doing about this risk?) CCG Operational Children's Board Joint SEND Board Single Children's Provider Children's Improvement Boards with LAs established CCG wide SEND Coordination meeting in place – reports to Children's Operational Board Mitigating Actions: (what further actions are needed to reduce the risk and close any identified gaps) identify key deliverables to address and reduce risk – January 2021 develop action plan with measurable outcomes and milestones January 2021 Complex Children's Review – ongoing - due Q4 Review of statutory services provided by CCHP – and an action plan to address gaps – due Dec 2020 due Feb 2021 Joint work on market engagement – ongoing due Q4 Closer working with NHS E/I on tier 4 CAMHS Due Q4 and commitment in place between all parties Developing an information sharing agreement – ongoing BNSSG involved with the framework for integrating care as the vanguard site for the South West. The framework is part of the NHS 			ablished ace – reports to eded to reduce the risk ce risk – January 2021 es and milestones Q4 HP – and an action plan due Q4 S Due Q4 and t – ongoing trating care as the	 Assurances: Written Statement of Actions being removed in all 3 LA areas Positive funded care audits Internal assurance provided through regular reporting of performance against key performance indicators and progress of action plans to Quality Committee, Commissioning Executive and Governing Body Internal Audit Safeguarding (Dec 2020) Internal Audit Continuing Health Care (April 2021) SEND Reviews independently undertaken by OfSTED and CQC Gaps in Assurance: (What additional assurances should we seek?) Information sharing agreements between all partners, to ensure that we can monitor the outcomes and improvements in life course. 	

additional services for children and young people with complex needs	
in the community. The Framework will support the Children and	
Families work stream within Healthier Together as it cuts across a	
number of programmes such as joint commissioning and new models	
of care.	

Funded Care Maturity Frai and staff sat Risk: There	e service achi mework with isfaction is a risk that ca	eving the "leading" I high levels of positive apacity and demand in	n the CHC service are	Director Lead: Rosi Shepherd Date Last Reviewed:	
not aligned, due to increased demand, complexity of cases and capacity and process issues within the team. This has the potential to result in delayed access to the right care for patients, financial pressures for the CCG and non-compliance against national framework standards.				16/06/21	
Risk Rating	Likelihood x impact	Risk Appetite	Risk Score Trend	Rationale for current score: The risk score is based on	
Initial	3X4=12			Likelihood score based on the increased numbers of outstanding	
Current	3x4=12			assessments/reviews (approx. 262 breached at 11.5.21), reduced capacity due to vacancies and sickness and the implementation of changed ways of	
Target risk	2x4=8			working required to deliver consistent and effective processes across the team.	
				Impact score is based on the financial risk posed by unknown demand, incorrect care packages to meet need and the ability to deliver against the standards set out in the national framework	
	/ith oversight			Rationale for target risk:	
Quality Committee, Strategic Finance Committee			ittee	The target risk score is to support the vision of BNSSG CCG delivering an outstanding service to the population we serve, being viewed as good system partners and achieving a high level of maturity against the national framework. Patients, families and carers will have confidence in the process resulting in a reduction in complaints.	
•		rrently doing about thi	,	Assurances: The sources of occurrences available relating to this objective are	
 Post dedicated to P3 to manage flow to support flow Paper to request support from external agency to manage backlog is being developed. Improved reporting data metrics developed – team and individual 				 The sources of assurances available relating to this objective are Internal assurance through monthly reporting through the Quality and Performance report to Quality Committee Internal assurance through Finance reporting to Strategic Finance 	
performance now able to be monitored across BNSSG				Committee	
 P3 surge bed initiative ended – staff returned to BAU Transformation working groups established – looking at standardising 				 Update to be provided to the Audit, Risk and Governance Committee External audit of CHC service – report expected June/July 	
processes across 3 localities				 Internal audit schedule compiled. Terms of References for individual 	

- Skill mix review of staff overseeing most complex cases as well as increasing the size of the team
- DOLS post out to advert the service has insufficient knowledge and skills in this area
- Improved process to identify new individuals under a DOLS order
- Proactive sickness monitoring taking place
- A review of Fast Track patients in receipt of funding beyond 12 weeks converted a significant number of patients to CHC. This will be under review going forward.
- Monthly Funded Care business meeting which reviews operational and financial performance

Mitigating Actions: (what further actions are needed to reduce the risk and close any identified gaps)

- Review against CHC maturity framework started but not yet complete
- Benchmarking against other CHC teams in relation to individual activity/performance expectations
- Improved understanding of the Fast Track position more people are opting to be cared for at home

- audits being developed. (reporting to monthly FNC Risk, Audit and Governance Group)
- Quarterly reporting to regional/national teams indicated BNSSG is a midranking performer
- External review of BNSSG by Deloittes to assess against maturity framework – report anticipated in July
- DOLS post successful recruitment
- Review of block bed purchases for CHC/FT identified low bed utilisation.
 Next step to look at area of high demand where investment may be required

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

No gaps identified

		Plan: Developing the		
Delivery of activities focussed on the CCG's workforce under the				
following them		and the above to a		
	•	and inclusive		
	cognised and			Director Lead: David Jarrett/Sarah Truelove
	nave a voice t			
	fe and health			
	ways learning			
We work f	•			
We are a f			landa de la desarrollona	
		ne progress made in d the CCG may be disru		Date Last Reviewed:
		CS resulting in falling s		12/06/21
increased turn				
Risk Rating	Likelihood	Risk Appetite	Risk Score Trend	Rationale for current score:
Lateral	x impact			Current temperature checks are not showing significant concern but as the
Initial	4X4 =16			transition path becomes clearer there remains a risk that this will change.
Current	3X4=12			People Plan Steering Group will continue to review the principal risk as part
Target risk	2x4=8			of the development and delivery of the People Plan and will update the risk,
				identifying controls, actions, and assurances for future Governing Body
Committee w	ith oversigh	t of rick		meetings Rationale for target risk:
	_	ic Finance Committe	26	Development of cohesive programme plan and the establishment of an
Coverning B	ody, olialog	or manoo committe	,0	Executive led steering group to drive delivery and with staff engagement
				included as part of the process
•		rrently doing about thi		Assurances:
	Team oversi	ght of the People Plan	development and	The sources of assurances available relating to this objective are:
Delivery • Individual	worketraame	in place with ad hoc s	eparate reporting routes	Internal source of assurance – ad hoc and subject specific reports to Governing Redy
Learning a	and Developm	nent Policy agreed and	d process established	Governing Body
		Development Panel		Annual Staff surveyInternal Audit of Appraisal Process
Equalities policies				Thomas Addit of Appraisal Frootso
		amended to include of	oversight of the	Gaps in Assurance: (What additional assurances should we seek?)
workforce	agenda			NHSE/I oversight of People Plan to be confirmed
Mitigating Ac	tions: (what	further actions are ne	eded to reduce the risk	
and close any	•		casa to roduco aro non	
			leadership to this work	

sustainability population hevaluating the Risk: As a rethere is a risk value which n	y and improve alth manage of out the cult of the cult hat there will hay result in fa	l be a continuing focu	through the use of of systematically opulation. Payment by Results on activity rather than wed population health	Director Lead: Sarah Truelove/Peter Brindle Date Last Reviewed: 09/07/21
Risk Rating	Risk Rating Likelihood x impact Risk Appetite Risk Score Trend		Risk Score Trend	Rationale for current score: The financial framework for H1 (the first half of 21/22) has been confirmed and the elective recovery fund (ERF) effectively incentivises a PBR culture.
Current	4x4=16			The payment regime to providers remains very different to the previous ways
Target risk	2x4=8			of working and requires significant education and cultural change towards a needs based, value based approach. The ERF makes this message more complex and organisations and individuals are not completely familiar or committed to taking a value approach across the system.
_	ance Comm	ittee, Governing Bo	dy, Clinical Executive, and Oversight Group,	Rationale for target risk: Reducing the likelihood would represent significant progress, but cultural change takes time and it is important we do this work systematically.
 Controls: (What are we currently doing about this risk?) Single regulator working with the system National proposed financial framework for 21/22 drives system working Healthier Together PMO (now integrated STP + CCG PMO teams) coordinating delivery of the system operational plan including transformation plans Reporting internally to Strategic Finance Committee on monthly CCG and system financial position Planning and Oversight Group and DoFs providing oversight of system financial position. 				Assurances: Internal audit report on savings plans and PMO processes, Monthly Governing Body reports Quarterly NHSE Assurance Meetings. Local response to NHS Long Term Plan agreed with NHSE/I Phase 3 financial plan agreed across the system H1 financial plan agreed across the system Gaps in Assurance: (What additional assurances should we seek?) H1 plan yet to be agreed with NHSE/I
 Clinical Cabinet provides oversight and decision making regarding clinical models and pathways Long term financial model developed as part of LTP response. The system's response to the Long Term Plan uses Value Based Healthcare as an organising principle. ICS financial framework is built around the value framework and gives 				

commitment to costing and transparency to ensure PHM data can be used to support value based decision making.

Mitigating Actions: (what further actions are needed to reduce the risk and close any identified gaps)

- Devise practical guides to 'doing' PHM and the Value approach. January 2021 Version one of the Value framework has been shared and is being used by the Community Mental Health Framework team, Learning Disabilities and Autism team, Integrated Care Partnership (ICP) model of care working group, Population Health, Prevention and Inequalities Steering Group and stroke reconfiguration programme. ICP PHM development programme started, focussed on developing the intelligent model needed for the community mental health framework target operating model response, and capacity building within ICPs. Value and PHM being designed into wider ICP organisational development programme.
- Update and engage DOFs across the system with work to date and the draft high level goals to gain their commitment to this work December 2020
- Ongoing engagement with the CCG Membership to use a Value Based Healthcare approach in developing their PCN and integrated care/locality plans Value/Team as now core members of the ICP Board. NHSE/I Wave II programme completed with publication of our system PHM roadmap due week of the 14th June 2021
- Support and encourage clinicians to identify areas of low value activity and explicitly commit to reducing and stopping it, particularly in the areas where productivity has been most impacted by COVID ongoing A shared, rapid evaluation process being has been developed to learn from the pandemic-induced changes, focussed on supporting continuation of high value changes
- Procure and implement an IT platform to identify, record and respond
 to clinical and 'person identified' outcomes Business case complete
 and will be submitted as System Transformation Reserve bid.
 date currently under review. Procurement due to be completed by
 summer 2021. Business case expected to be complete end of June
 2021 followed by procurement process. Pilot projects underway in
 North Bristol Trust focussed on shared decision-making in surgery
 and initiated for the new long Covid service
- Develop a readiness plan to support clinical teams and patients to think about outcomes so that the platform is used with a number of

clinical teams already engaged and ready to engage with the system platform.

- Re-launch the Value Programme which will report into the Population Health, Prevention and Inequalities Steering Group
- Develop a plan for embedding shared decision making across the system in recognition of evidence to suggest that it is a value-adding activity. Bid for support for the work being made to the System Transformation Reserve will be submitted. Successful extended Clinical Cabinet workshop in early May triggered initial thinking and tested appetite for shared decision making as part of personalised care.