Version	Principle Risk 'What could prevent this objective being achieved and where was it identified'	Initial Assessment L= Likelihood I = Impact		
		L	I	Rating
Key Principle 1 **Deliver a continually improving Healthcare and Patient Experience** **Key Principle 2** **Develop a 'true membership' organisation (active engagement and clinically led organisation)** **Key Principle 3** **Achieve Financial sustainability for future investment** **Key Principle 4** **Visible leadership of the local health economy through behaviour and action** **Key Principle 5** **Grow the leaders for tomorrow (Business Continuity)**				
C.McI /JD	Vacancy for Mental health & LD Programme lead	5	3	15
C.McI /JD	Resignation of Women & Childrens Commissioner	5	3	15
C.McI /JD	Vacancy for Planned care post	5	3	15
C.McI /JD	Older People's commissioner vacant due to secondment	5	3	15
C.Mc/JD/DMcG	Access to PID, potential to restrict/limit redesign e.g. frequent users of ambulance servcies, frequent emergency admissions	5	4	20

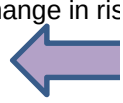
C.Mc/JD/DMcG	Community PAM - lack of clarity regarding the costs of individual services make redesigning community servcies very difficult and can be a barrier to change	4	4	16
C.Mc/JD/DMcG	Community Trust performance data is not comprehensive so there is a risk of hidden performance issues	5	4	20
CMc/JD	Community Trust - waiting list concerns across a number of services, both 18wks and other e.g. CAMHS, paediatric psychiatry, paediatric therapies, APCS services etc	5	4	20
CSU/DMcG	Lack of contract monitoring = QIPP monitoring, risk on delivery of QIPP , when no view on Month 1 at mid July point	5	4	20
CMc/EP	DTOC - high level of in patient delays - adversely affecting A&E performance in SaTH	5	4	20
CMc/JD	Paed admissions increase	5	4	20
CMc/BG	Paediatric reconfiguration - short term x4 bed closure	5	2	10
CMc/DW	Cancer - risk associated with inconsistent achievementsof targets and future capacity/pathway issues	3	3	9

CMc/PC/JP	CAMHS- lack of MH commissioner has delayed progress on CAMHS redesign, linked to risk on BAF	4	3	12
CMc/JD	Changes in commissioning responsibilties e.g LAT, Public Health, Specialised Commissioning - impacting on patient pathway decisions and taking up a huge amount of commissioners time working through individual issues to gain clarification of responsibilities.	5	3	15
CMc/PC	GP counselling risks identified upon sudden death of counsellor :- Record keeping Patient confidentiality Hidden waiting lists	4	4	16
CMc/PC	LD self assessment framework - national self assessment will be launched in the next few weeks, will require signifcant resource from CCG alongside the Local Authority -risk is due to lack of LD commissioning post.	4	3	12
C Mc/SR/JD	Dementia - loss of older peoples commissioner has affected progress on dementia strategy and support for Dr Sal Riding as CD	5	3	15
CMc/EP/JD	Lack of winter monies - if no winter monies made available this year there is a significnat risk of poor performance during the Winter if additional contingencies cannot be put in place due to lack of money.	3	4	12
CMc/EP/PCl/BG	Frail & Complex risks:- Lack of workforce to implement model of care Not one of the ATOS priority projects QIPP was based on this project being rolled out	4	4	16
PH/WS	Ophthalmology risks:- Loss of clinical engagement as a result of encouraging new providers onto the patch New providers don't have sufficent short term capacity to match demand Affordability of initial activity required to eliminate backlog and implement NICE tags	3	4	12
NW/IN/JD	Rheumatology - risk of SaTH being unable to provide the service due to the deanery removing a clinical post.	5	4	20

CMc/JD	Lack of development monies for redesign - risk is that only redesign projects that can deliver in year savings will now progress. Transformational change is unlikely to be achieved in this way	5	4	20
CMc	Dermatology - risk associated with introduction of Teledermatology and ability of existing local services to manage short term rise in demand as a result.	4	3	12
WS/SR/JP	Cardiology - issues with current demand exceeding clinical capacity at SaTH despite pathway redesign including Advice & Guidance and straight to test.	4	3	12
CMc	Temporary consolidation of Stroke Services at PRH for July/August - risk is potential deterioration in hyper acute stroke services due to temporary reduction in consultant capacity.	4	4	16

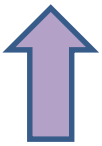
CMc- Carol McInnes	
JD – Julie Davies	
BG- Bill Gowans	
JP –Julian Povey	
SR- Sal Riding	
DMcG- Donna McGrath	
DW- David Whiting	
WS- Wendy Southall	
EP- Emma Pyrah	
PC- Paul Cooper	
PCl- Peter Clowes	
PH -Paul Haycox	
IN-Ilse Newsome	

No change in ris



Risk Level reduc

Risk level increa



Assessment of risk level - Low / Medium / High / Extreme Risk	Risk Appetite Level of exposure to the risk the CCG is willing to accept	Key Controls 'What controls / systems are in place to manage the risk'

Extreme	4	CSU community and mental heath contract lead providing support for MH and Head of planning & partnership has led on LD in the interim
Extreme	4	TBD - being agreed by 19th July
Extreme	4	Some areas being managed by LTC and Urgent Care commissioners. Cover for pain, Rheumatology and T&O still being provided by N.White.
Extreme	4	Some areas being managed by LTC, Urgent Care and Cancer commissioners. Head of Planning & Partnerships covering voluntray sector related work
Extreme	6	Pseudonimisation process being developed by the CSU

Extreme	4	Agreement with the CT that this will be agreed in year
Extreme	4	Data Quality improvement plan is included in the contract
Extreme	4	As above
Extreme	4	None
Extreme	2	Daily monitoring of delays in place
Extreme	4	Monthly contract monitoring Monthly project board in place to review and develop:- Pathways Systems & processes Agree commissioning arrangements (coding & counting)
High	4	Daily monitoring of paediatric bed base / capapcity in place
High	4	Regular monthly monitoring of targets and monthly Cancer board to be implemented to track delivery of action plan and manage future risks

High	4	Temporary resource drafted in alongside local authority (Jo Robbins) Regular performance meetings
Extreme	2	None
Extreme	1	Short term control- practice obtained patient records, ensured confidentiality and security, confirmed patient details and status of referral and waiting time.
High	2	LD commissioner will be in post on 22nd July and will lead this piece of work on behalf of the CCG
Extreme	2	No capacity within the current resource to control this risk
High	9	Three scenarios being planned for , same money as 2013, 50% and none.
Extreme	4	Mapped original QIPP against new ATOS streams and ongoingwork programmes for urgent care and LTCs -
High	4	Regular project board with local Optoms, Consutlants and the new providers Can't control capacity of new providers Raised risk of affordability with CFO
Extreme	1	Developed plan with RJAH for them to take over the service , but still delivered at RSH. Temporary additional consultant cover provided by RJAH paid for by CCG during transition.

Extreme	4	Any developments are intially being considered by Supporting Delivery Group and on to QPR if the return on investment can be demonstrated.
High	4	Delay implementation of Teledermatology until assurance can be given regarding the current providers ability to flex capacity in the short term to meet the expected temporary rise in demand
High	6	SaTH continuing to do waiting list initiatives and brought in temporary additional consultant capacity to reduce passed max wait list
Extreme	4	Consolidation has minimised risk by putting limited consultant resource onto 1 site

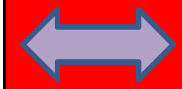
sk level since previous report

ed since last report

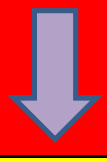
sed since last report

e Risk Assurance Framework
edesigr

Source of Assurance Where can we gain evidence (internal or external) that our controls / systems on which we are placing our reliance are effective?	Current Assessment L= Likelihood I = Impact			Assessment of risk level - Low / Medium / High / Extreme Risk
	L	I	Rating	
Track provider performance and key performance measures for MH and LD	4	3	12	High 
Track provider performance and key performance measures for Women & Childrens services	4	3	12	High 
Track provider performance for 18wks RTT, passed max waits etc.	4	3	12	High 
Head of Programmes & Redesign maintaining overview of projects and need	4	3	12	High 
New process used to allow individual case studies to be included in redesign work	4	3	12	High 

CCG requests internal costs of service from provider when embarking on a service re-design, however yet to be received	4	3	12	High 
Monthly contract performance meetings	5	3	15	Extreme 
As above	5	2	10	High 
No controls = no source of assurance	5	4	20	Extreme 
Daily report for 16/7/13 showed level of 8	2	1	2	Low 
No current assurance due to no YTD contract monitoring	4	3	12	High 
Regular conference calls to assess current position	4	2	8	High 
Monthly performance has improved in May and June compared to April	3	2	6	Moderate 

Limited until PC in post, weekly operational calls in place to manage any short term issues	3	3	9	High 
No assurance	5	3	15	Extreme 
CCG taken responbility for securing alternative provision and esnuring patients seen as soon as possible.	3	3	9	High 
Regular update on progress of self assessment will be reported to Senior Managers Meetings	3	2	6	Moderate 
Head of Programmes & Redesign maintaining overview of projects, need and meeting regularly with SR	4	3	12	High 
Without any funding no assurance can be provided	3	4	12	High 
Current re-mapping matches QIPP commitments. EP is project manager for F&C and it is being progressed via Transformation part of the Urgent Care Network Board	3	3	9	High 
Good attendance at project board from clinicians, local Optom advisor supportive of the work, draft joint capacity plans from SaTH and Viewpoint will confirm level of capacity	3	3	9	High 
Eliminated 18wk backlog and ensure patients seen within 18wks and passed max wait backlog eliminated.	2	2	4	Moderate 

Limited as future delivery is at risk without transformational change	4	4	16	Extreme 
Confirmation that additional capacity can match expected temporary rise in demad	3	2	6	Moderate 
Assurance is passed max wait is coming down but not sustainable.	3	3	9	High 
CCG has requested for QIAs for the change, copies of new pathways, monthly contract performance review agenda has been amended to include this as a stand alone item	3	3	9	High 

Action / Lead Name / Timescale 'Action to be taken'	Residual Target Risk Score (after actions completed)			Assessment of risk level - Low / Medium / High / Extreme Risk
	L	I	Rating	
Paul Cooper starts in post 22nd July 2013	2	2	4	Low
Interviews conducted on 15th July, post offered awaiting acceptance.	2	2	4	Low
Interviews scheduled for the 15th August.	2	2	4	Low
Going out to advert for fixed term post to provide cover for the duration of the secondment	2	2	4	Low
Output from CSU workshop shared with programme leads, and working with CSU when process available	2	2	4	Low

Awaiting costs from CT , risk will reduce to score of 9 when this is received.	4	1	4	Moderate
Information for highlighted services has been requested. Received for CAMHS only to date. CSU have been asked to consolidate specification waiting time requirements to monitor against. Risk score will be reviewed when data matched against specification - end of August.	4	1	4	Moderate
See above	4	1	4	Moderate
Cause is national issue, CFO escalating to CSU and Area Team	2	2	4	Moderate
Ongoing management via Urgent Care Lead	2	1	2	Low
First project board meeting held 16/7/13, priority pathways agreed, and outline project plan for implementation agreed. Service review of community paediatric services has also been completed to identify gaps in provision.	2	2	4	Moderate
Pathway work above will reduce risk in time for Winter 2013/14	3	2	6	Moderate
Action plan has been agreed with SaTH and monthly Cancer Board being set up.	2	2	4	Moderate

Head of Programmes & Redesign managing current short term risks directly with CT until PC starts 22nd July 2013	2	2	4	Moderate
Raising with Area Team as an issue which is having a serious impact on the day to day workload of the commissioning team.	2	2	4	Moderate
Secured alternative provision for CBT services, confirmed accuracy of records, writing out to patients wiating offering alternative provider. Review of GP counselling will be undertaken by the new MH commissioner and recommendations made as to future	1	1	1	Low
Paul Cooper starts in post 22nd July 2013. Once work on assessment begins, regular updates/issues will be brought to Senior Managers as required	1	2	2	Low
Going out to advert for fixed term post to provide cover for the duration of the secondment	2	1	2	Low
Confirming committed spend against Frail & complex monies to identify any that could be re-directed to minimise impact for Winter. Ensuring this is kept on the agenda for Area Team meetings.	3	3	9	High
Matching of QIPP to be reviewed at Supporting Delivery Group F&C revised implementation plan going to the next UCN Transformation board	2	2	4	Moderate
Paul Haycox chairing project board with support of Optom advisor and Wendy Southall. In addition SaTH have provided some project management support to the Viewpoint work and are now leading on that element. CCG to retain lead of medium-longer term solution with " The Practice".	2	2	4	Moderate
Finalised formal transfer date with RJAH and complete formal contrcat variation to transfer from SaTH contract to RJAH	1	1	1	Low

Team focusing on delivery of projects critical to this year and planning for projects that require investment for 2014/15.	4	3	12	High
Currently working with two local providers to determine additional capacity that could be available and map to projections of impact of teledermatology.	2	2	4	Moderate
Cardiology pathway group to look at this issue as well as LTC implications.	2	3	6	Moderate
Review QIA (just received), reviewing meeting set up at the end of July,	2	2	4	Moderate

Better Care Fund Assurance Framework. V1 Quarter 4 2013/14

Version	Principle Risk 'What could prevent this objective being achieved and where was it identified'	Initial Assessment L= Likelihood I = Impact			Assessment of risk level - Low / Medium / High / Extreme Risk	Risk Appetite Level of exposure to the risk the CCG is willing to accept	Key Controls 'What controls / systems are in place to manage the risk'	Source of Assurance Where can we gain evidence (internal or external) that our controls / systems on which we are placing our reliance are effective?	Current Assessment L= Likelihood I = Impact			Assessment of risk level - Low / Medium / High / Extreme Risk	Action / Lead Name / Timescale 'Action to be taken'	Residual Target Risk Score (after actions completed)			Assessment of risk level - Low / Medium / High / Extreme Risk
		L	I	Rating					L	I	Rating			L	I	Rating	
Key Principle 1																	
Key Principle 2																	
Key Principle 3																	
Key Principle 4																	
Key Principle 5																	
	Impact on local system in particular DTOC of neighbouring Welsh Health Board policy	4	3	12	High		Limited as this point to individual relationships with Welsh commissioners and escaltion via accountable officers if required	Daily monitoring of DTOC for all commissioners received and issues escalated to LHBs if required	4	3	12	High	SCCG linking with Herefordshire to have joint meetings with Powys regarding interdependancies and cross border issues	3	3	9	High
	Shared providers with Telford & Wrekin CCG and differences in commissioning policy could cause operational issues for providers	4	3	12	High		Joint collaborative commissioner meetings in place and planned joint meetings with providers as their individual impact of BCF is more clearly defined.	Feedback from our providers via our contract review meetings	3	3	9	High	Timetable of joint meetings with providers to be arranged by mid April	3	2	6	Moderate
	Ensuring appropriate links between the Future Fit prgramme and the development of the BCF and Council redesign programme - otherwise could lead to a risk of fragmentation of services and the lack of a coherent vision for local services	3	4	12	High		Ensure progress and developments from Future Fit feed into the development of the BCF via the service transformation group. Local Authoity collegaues have a place on the FutureFit programme board. Health & Wellbeing Delivery Group also consists of CCG, council leads	New service specifications are jointly signed off by the council and CCG as appropriate	3	3	9	High	Service Tranformation Group to be set up from April 2014 across the health economy.	2	2	4	Moderate
	Financial implications of - rurality, Welsh Boarder issues (Net importer for A&E and MIU) Wales not coverd by BCF,	4	3	12	High		Financial allocations for both CCG's and LA are known. Draft Budgets approved by Boards/ Cabinet. BCF target allocation for 14/15 and 15/16 are known CCG QIPP targets for both years are known	Reports from Finance Sub group to the Health and Wellbeing Board	4	3	12	High	Final CCG and LA budgets for 14/15 andf 15/16 signed off by Board/ Cabinet. April 2014. BCF Finance and Performance sub group to be set up by the end of April 2014 with first reports available for June Health & Wellbeing Board	3	2	6	Moderate
	IT systems - Older systems in place that are not compatible with each other. Further ahead in primary care	3	3	9	High		Draft CCG IM&T Strategy. Joint CCG IM&T forum	Progress against IM&T Strategy (which includes collaborating with providers and the LA) reported to QPR	3	2	6	Moderate	Finalise and sign off IM&T Strategy by end of May 2014. Hold health Economy (inc LA) IT forumfor shared understanding of issues. June 2014	3	1	3	Low
	Recruitment and retention issues particularly for medical staff are a risk to transforming services and the workforce required to deliver them	3	4	12	high		Workforce forms a key strand of work under the FutureFit programme and the appropriatw links will be made between this and the development of work aligned to the BCF	Developments in relation to FutureFit will be presented regularly to both the Health & Wellbeing Board and the Health & Wellbeing Delivery Group	3	4	12	High	Workforce plans to be developed. Timescale to be agreed	3	4	12	High
	Plan doesn't address health inequalities across all client groups	3	3	9	High		Equality Impact Assessment to be completed on each service change	EIAs to be signed off will ensure all client groups are considered as required	3	2	6	Moderate	EIA to be a key stage in the individual service transformation plans	2	2	4	Moderate
	Developing different plans across Shropshire & Telford & Wrekin	3	3	9	High		Collaborative Commissioning Forum, Executive Discussion Group are forums where such plans can be discussed	Areas of difference will be identified via the collaborative commissioning group - some will be necessary due to differing rurality and demographics	3	3	9	High	BCF added as astanding item on the Collaborative Commissioning agenda	3	2	6	Moderate
	Implications of the Care Bill has several risks linked to BCF:- metric associated with admission rates to care homes will be impacted by the change in the eligible population, financial pressures of the care bill may impact on the council's ability to contribute to further integration	5	3	15	Extreme		Risk to this indicator and metric that admissions will increase not because of new admissions but because the financial threshold in the Care Bill will increase and make more people eligible for funded care	Position will be monitored by the Health and Wellbeing Delivery Group and its key sub groups	5	3	15	Extreme	Further guidance awaited from NHS England/ LGA	5	3	15	Extreme

	Unintended consequences of service change that affects quality	3	3	9	High		Complete a full quality impct assessment on evry proposed servcie change	Service Specification cannot be approved without an associated QIA signed of CCG, LA and provider (where appropriate)	2	2	4	Moderate	QIA to be a key stage in the individual service specification sign off process	2	1	2	Low
	BCF deliverables may not provide sufficient support to the costs of introducing the Care Bill.	4	4	16	Extreme		Mitigations to be confirmed following receipt of further guidance in order to address the following risks • Increased financial pressure for LA as more people are eligible for LA funded support • Additional social work assessments required and the cost of providing these • Increased number of deferred payments with potential impact on cash flow • Costs associated with providing additional information and advice • Increase in number of people in residential and nursing care homes as existing residents who fund their own care become eligible for LA funded care due to change in capital threshold. This will impact on the performance metric • The requirement to provide support and direct payments for carers and the financial impact of this • The financial impact and resources required in changing IT systems in order to manage an individual's care account • Resources and costs of staff training	Insufficient infoamtion available at present to define controls that will mitigste the risks identifed.	4	4	16	Extreme	The local Authority will lead on identifying the risks and how they may be mitigated . This will include consualtation with the independent care sector in order to identify the number of people who currently fund their own care, workforce planning and development, siupport required fro cars and IT resources required. With regard to tiemscales intial scoping wotk will be undertaken January 2014 to May 2014, with action plans developed, Howerver timescales will depend on enactment of the legislation in November and the level of guidance received pre and post enactment.	3	3	9	High
	Service transformation does not deliver efficiencies to support Health & Social Care delivery plans (Risk to delivery of QIPP)	4	4	16	Extreme		Monthly Supporting Delivery meetings of the CCG review the progress of QIPP. The delivery of QIPP is directly related to the availability of the full BCF fund in 15/16. Draft QIPP Plan fully identified and signed off by CCG Governing Body for 14/15 and a high levle plan for 15/16. provider engagement at an operational and strategic level on QIPP ambitions. Majority of QIPP signed off in provider contracts	QIPP monitoring thorugh the Supporting Delivery Group (QPR sub group)	4	4	16	Extreme	Sign off final QIPP plan at at April Board. April 2014. Continue with provider engagement through BCF and Supporting Delivery Forums. On going	3	3	9	High

ST- Sam Tilley	
JD – Julie Davies	
SC - Stephen Chandler	
RH - Ruth Houghton	
RT - Rod Thomson	
RB - Ros bridges	
DM - Donna McGrath	

No change in risk level since previous report

Risk Level reduced since last report

Risk level increased since last report

Risk Matrix

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

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

		Low risk
		Moderate risk
		High risk
	15 - 25	Extreme risk