Primary Care Commissioning Committee

Extract from Corporate Risk Register – to June 2018 PCCC meeting

Risk Ref. No.	Source	Owner	Risk Description	Inherent risk score			Required controls and actions to reduce/mitigate risk (with dates)	Review Dates: (monthly, quarterly)	Monitor/ Review body	Residual Risk Score and Rating			Is risk rating accept-able
				L	I	RR				L	I	RRR	Yes/No
CATEGORY: Primary Care Commissioning Committee (PCCC)							**Lead: Director of Primary Care (HC)**						
PrC2a **Re-worded at request of Governing Body to describe risk more clearly.**	PCCC	Helen Clark	Recruitment and retention difficulties could result in practice closures and make it difficult for primary care to take on a broader range of services as envisaged by the ICS.	4	4	16	**June 2018 (no change in rating):** • Workforce workstream of GPFV underway and linked with broader ICS workforce strategy. Progress reported to PCCC through GPFV report. • CCG now working with GP provider alliances on this area; all practices but one are now in an alliance and all alliance business plans include schemes to proactively address workforce issues. • CCG linking with primary care leads across Thames Valley on this area, CCG AO is now lead AO for BOB primary care workstream. Workforce modelling underway and will inform more coherent primary care workforce strategy to be developed over coming months, linking with others in BOB as appropriate. This will draw together the multiple projects currently underway. • Primary care team continuing to monitor and offer support to address pressures in individual practices. Practices are reporting increasing pressures particularly around GP recruitment and locum costs.	Quarterly	PCCC	4	4	16 ↔	No – more robust strategy required, actions underway to address this.
PrC2b	PCCC	Rebecca Clegg	Viability of existing providers and ability to deliver new service models described in Primary Care Strategy	3	4	12	**June 2018 (no change in rating)** • MPIG review phased over five years with funding reinvested in global	Quarterly	JPCCC	2	4	8 ↔	Yes

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			may be affected by funding issues including PMS review and phasing out of MPIG.				sum. Analysis of impact now complete. • PMS review also phased over 5 years. Recovery of funding and reinvestment through Quality CES now being implemented. Practices have full forecast of net impact nad capping has been agreed to mitigate most significant losses. However impact on future practice financial sustainability is still unclear. • Residual PMS funding has been used to create Transformation Fund in South Reading in particular. • All but one practice now part of GP provider alliance – alliances will work together to create efficiencies and build resilience as well as to identify new potential income streams as part of the Berkshire West ICS. £3 per head transformation monies available to alliances – process for second tranche agreed. • All GPFV funding streams made available to practices and alliances to address vulnerability and support transformation including sustainability and resilience funding, online consultation funding, funding for care navigation/document management, PM development funding. Working with Alliances to develop plans for Enhanced Access which would potentially give them access to associated funding.						
PrC2iii – NWR	PCCC	Debbie	Practices in special measures (Circuit				**June 2018: (risk rating reduced)**	Quarterly	JPCCC				

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CCG **Re-worded at request of Governing Body to describe risk more clearly. General wording removed as no other practices in special measures.**		Simmons	Lane and Priory Avenue surgeries) could be closed if quality issues are not addressed, resulting in a potential lack of primary care capacity.	4	4	16	• Circuit Lane APMS contract terminated on 31st March 2018 and services are now being provided by Western Elms Surgery. Patient feedback is very positive to date and no quality concerns have been identified. CQC inspection awaiting. • Priory Avenue contract will be terminated on 30th June 2018 and a dispersal process is currently underway. Local practices have sufficient capacity to accommodate all patients although not all patients will get their first choice of practice.			2	4	8 ↓	Yes
PrC4	PCCC	Cathy Winfield	Members of the public will not be willing to accept the models of care resulting from the Primary Care Strategy, thereby preventing effective implementation.	3	4	12	**June 2018 (no change in rating)** • Addressing this risk relies on effective engagement around GPFV and resulting service models. Previous engagement undertaken around Primary Care Strategy but now need to review approach as part of refreshing GPFV plan, increasingly working with alliances to engage population at a locality level (including through existing Patient Participation Groups and other networks) but also joined up with broader ICS engagement approach. • ICS Communications lead now appointed and will be key link. • Enhanced Access work will provide early test of patient response to new delivery arrangements.	Quarterly	PCCC	3	4	12 ↔	No – to be re-assessed once mitigating actions progressed

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				L	I	RR				L	I	RRR	Yes/No
PrC5	PCCC	Helen Clark	Practices wil not engage with re-design of same-day access and extended hours provision thereby hampering efforts to achieve sustainability by enabling practices to bettermanage demand and adversely affecting ability to reduce A&E attendances and non-elective admissions and meet national requirements to expand seven-day provision.	4	4	16	**June 2018 (risk rating reduced):** • GP Alliances now developing detailed delivery plans building on existing provision and in line with new national timescale of 1st October 2018. • Funding and contractual arrangements are being clarified with a view to moving to implementation phase from end of June. Some key implementation issues still be resolved e.g. interoperability, access to results, appointment booking arrangements. • Progress reported to PCCC through GPFV Programme Report.	Quarterly	PCCC	3	4	12 ↓	Yes as reducing
PrC6	PCCC	Helen Clark	Lack of effective Primary Care Support Services through Primary Care Support England (PCSE, provided by Capita) will have adverse impact on GMS/PMS/APMS service delivery including availability of medical records, list management, registrar and pension payments, availability of clinical supplies and timely completion of changes to the performers' list.	5	4	20	**June 2018 (no change in rating):** • Capita contract is managed by NHSE at a national level. Rectification plan currently in place and regular updates being received through TV Primary Care Forum showing progress made. PCSE updates also going to practices directly. Practice Manager leads asked to continue to provide updates on numbers and range of issues so Primary Care Contracts Manager is aware. • NHSE TV local team liaising with local NET (National Engagement Team) manager around practice specific issues. • Some concerns emerging regarding financial health of Capita based on press coverage – situation being monitored and contingency plan	Monthly	PCCC	4	4	16 ↔	No – finance team developing contingency plan.

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				L	I	RR				L	I	RRR	Yes/No
							being developed by finance team.						
PrC7	PCCC	Helen Clark	It may not be possible to identify a new provider for the Violent Patients' Service following the expiry of NHSE's existing arrangement in June 2018.	4	3	12	**June 2018 (risk rating increased):** • Local solution being sought through discussion with Westcall. Discussions continuing but no firm agreement reached. Existing contract expires in July. • Exploring opportunities to link with solutions in place in neighbouring CCGs. • Issue escalated to CEO level, progress being reviewed weekly.	Quarterly	PCCC	5	3	15 ↑	No – has been escalated to CEO level and progress being reviewed weekly.
PrC8 – South Reading CCG	PCCC	Helen Clark	Practice sustainability pressures and population growth could lead to a gap in primary care provision in the Whitley area.	3	4	12	**June 2018 (no change in rating)** • SR CCG and Reading Primary Care Alliance continue to support practices in the area to develop plans for long-term sustainability through mergers and/or collaborative working, including support to practice previously expected to be part of a merger that did not proceed. • Whitley branch surgery closure complete, no major capacity issues. • In principle support given to premises scheme which would re-house South Reading Surgery as well as allowing capacity to absorb population growth. Further plans being developed around Green Park population growth. • PCCC to consider next steps on Shinfield contract (held by South Reading Surgery) by September 2016.			1	4	4 ↔	Yes – need to continue to monitor to ensure plans progress as currently envisaged.

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Annex 1: Extract from CCG's Risk Management Strategy 2015-16

Risk Assessment Tool (Risk Matrix)

The CCG has adopted a risk assessment tool, which is based on a 5 x 5 matrix *(Used by Risk Management AS/NZS 4360:1999, revised 2004)*. The risk matrix shown below is drawn from the National Patient Safety Agency *'A Risk Matrix for Risk Managers'* guidance published in January 2008. Risk assessment involves assessing the possible consequences of a risk should it be realised, against the likelihood of the realisation (i.e. the possibility of an adverse event, incident or other element occurring which has the potential to damage or threaten the achievement of objectives or of service delivery). Risks are measured according to the following formula:

Likelihood x Impact

All risks need to be rated on two scales - Likelihood and Impact (consequences), using the scales below.

Likelihood

To establish the Likelihood score go to the Likelihood definition scale below. Choose the most appropriate likelihood of the event occurring again from the five rows. The likelihood score is the number at the left hand end of the row.

Level		Detail Description examples
1	**Rare:**	May occur only in exceptional circumstances
2	**Unlikely:**	Could occur at some time
3	**Possible:**	Might occur at some time
4	**Likely:**	Will probably occur in most circumstances
5	**Almost certain:**	Is expected to occur in most circumstances

Impact (consequences, severity)

To establish the Impact score use the Impact definition scale below. For the risk/issue you have identified, consider what would happen if this risk were to be realised and choose the most appropriate row. The Impact score is the number at the top left-hand end of the selected row.

	1	2	3	4	5
Descriptor	**Negligible/Insignificant**	**Low (Green)**	**Moderate**	**High**	**Very High**
Objectives/Projects	Insignificant cost increase / schedule slippage. Barely noticeable reduction in scope or quality	< 5% over budget / schedule slippage or minor reduction in quality / scope	5 -10% over budget / schedule slippage or reduction in scope or quality.	10 - 25% over budget / schedule slippage or failure to meet secondary objectives	> 25% over budget / schedule slippage or doesn't meet primary objectives
Injury (Physical/Psychological)	Minor injury not requiring first aid or no apparent injury	Minor injury or illness, first aid treatment needed	RIDDOR / Agency reportable	Major injuries, or long term incapacity / disability (loss of limb	Death or major permanent incapacity
Patient Experience /Outcome	Unsatisfactory patient experience not directly related to patient care	Unsatisfactory patient experience - readily resolvable	Mismanagement of patient care, short term effects (less than a week)	Serious mismanagement of patient care, long term effects (more than a week	Totally unsatisfactory patient outcome or experience
Complaints/Claims	Locally resolved complaint	Justified complaint peripheral to clinical care	Below excess claim. Justified complaint involving lack of appropriate care	Claim above excess level. Multiple justified complaint	Multiple claims or single major claim
Service Business/Interruption	Loss / interruption > 1 hour	Loss / interruption > 8 Hours	Loss / interruption > 1 day	Loss / interruption > 1 week	Permanent loss of service or facility
HR /Organisational development **Staffing and Competence**	Short term low staffing level temporarily reduces service quality (< 1 day)	Ongoing low staffing level reduces service quality	Late delivery of key objective / service due to lack of staff. Minor error due to ineffective training. Ongoing unsafe staffing level	Uncertain delivery of key objective / service due to lack of staff. Serious error due to ineffective training	Non delivery of key objective / service due to lack of staff. Loss of key staff. Critical error due to insufficient training
Financial	Small loss	Loss > 0.1% of budget	Loss > 0.25% of budget	Loss > 0.5% of budget	Loss > 1% of budget
Inspection/Audit	Minor recommendations. Minor noncompliance with standards	Recommendations given. Noncompliance With standards	Reduced rating. Challenging recommendations. Noncompliance with core standards	Enforcement Action. Low rating. Critical report. Major non compliance With core standards	Prosecution. Zero Rating. Severely critical report
Adverse Publicity/Reputation	Rumours	Local Media - short term. Minor effect on staff morale.	Local Media - long term. Significant effect on staff morale	.national Media < 3 Days	National Media > 3 Days. MP Concern (Questions in House)

Risk Score/Rating

To calculate the **inherent** risk score/rating: Select the appropriate row for Likelihood and the appropriate column for Impact.

- The square where the rows intersect represent the risk score/rating, e.g. a risk with a likelihood of 2 and an impact of 3 would be scored as 6 and rated YELLOW (M = Medium).
- The colour codings categorise risk as follows: Low (Green), Medium (Yellow), High (Amber), Very high (Red).

[This table may not be applicable for all situations. If this is the case, the table sets out a scale of parameters which can be used as comparable measures.]

Please note:
The **inherent risk** score/rating should **not** take into account the controls and assurances **already** in place to manage the risk. These should be taken into account w**hen calculating** the 'residual' risk score**.**

Risk Scoring Matrix

The 'Impact' and 'Likelihood' scores are multiplied together to calculate the **inherent** risk score – see example above.

		Impact				
Likelihood		1	2	3	4	5
	1	L	L	L	L	L
	2	L	L	M	M	H
	3	L	M	H	H	VH
	4	L	M	H	VH	VH
	5	L	H	VH	VH	VH