BERKSHIRE WEST CLINICAL COMMISSIONING GROUPS

Corporate Risk Register (November 2018)

Risk Ref. No.	GBAF Strategic Objective	Risk description, source and owner	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: Quality **Lead: Nurse Director**												
Q6	SO2	There is a collective risk to provider workforce management, total establishment staffing levels. All provider organisations with the local health economy have detailed risk regarding workforce. More specifically this is with reference to patient facing staff at a variety of AfC bands, within a number of clinical specialities. Therefore, there is increased reliability on bank and agency staff which pose a risk to the continuity of patient care and have a financial impact. Source: CCG Quality Team **New risk added December 2017**	4	4	16	There are a number of methods of monitoring the workforce key performance indicators, this is completed on a monthly basis as per contractual requirement. These included: • Turnover • Sickness • Agency spend Within the Clinical Quality Review Meetings – provider commissioner interface, there are requested for 'deep dives' relating to Human Resource issues and provider actions to mitigate significant risk. Additionally vacancy rate, recruitment and retention plans are discussed during Quality assurance Visits. More recently there is the Integrated Care System workforce steering group which has been recently launched in order to address some of these issues collectively. This could include the exploration of working differently across the system in order to maintain safety and meet patient demand. **Last reviewed: September 2018 JT** **Next review: November 2018 Quality Committee**	Quarterly	Quality Committee	4	4	16	NO (national issue, however we are working as ICS to improve local picture)
CATEGORY: Finance **Lead: Chief Finance Officer (RC)**												

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			L	I	RR				L	I	RRR	Yes/No
F1	S03	The financial plan contains significant risk to delivery of agreed financial position particularly in relation to: • acute contract over-performance • mental health placements (key issue for 2018/19) • CHC Source: CFO	4	4	16	System Control Total option agreed by all parties. Payment mechanisms agreed by all parties Work on understanding provider cost being developed with NHSE/I support. Now mobilising with KPMG. Work on understanding all risks and mitigations complete with new risk/mitigations sharing framework in place and updated monthly. Improved scrutiny of non-local contracts required (dependent on capability of CSU staff). Raised as an ongoing issue with CSU. Repeated at meeting with CSU on 21 May along with clear message of intent to withdraw from the service. Repeated with CSU on 15/08/18. CCG team now taking this forward. Meeting held with Thames Valley CFOs to discuss wider implications of in-housing PPM and business case drafted and sent to NHSE. Further work require on SCAS contract management proposal.. Improved reporting for programme boards, developed in 17/18 presented to Finance Committee in June.Q1 with increased focus from finance team following completion of merger work. Continued regular dialogue with NHSE regarding the financial position and any risk/opportunities. CCG in year mitigations in place and	Weekly Monthly Monthly Monthly Monthly Monthly	ICS CFOs ICS Unified Exec with feedback to Finance Committee and GB Finance Committee Programme Boards Calls with NHSE plus NHSE FLT meetings. Finance Committee and GB	4	4	16 ↔	NO (Actions in train but need time to impact and benefits of ICS still in developm ent)

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			L	I	RR				L	I	RRR	Yes/No
						reviewed monthly, but continuing to report £2m net risk. **Last reviewed: November 2018 CFO** **Next review: December 2018**						
F2	S03	2018/19 CCG and System Efficiency Programme not delivering as planned. Source: CFO	4	4	16	System Efficiency Plan for 18/19 developed for discussion with ICS groups. Deep dive schedules for September 2018, Unified Executive. Deep Dive planned for FRG 5 November 2018. CCG CIPs/Efficiency identified at £5.5m and rated low risk. To be reviewed by FRG (terms of reference to be reviewed 2018). Urgent work now needs to ensure alignment of CCG and provider teams and increase the focus on delivery. Review of Right Care Opportunities underway with workshop being held for respiratory and gastro. Approach agreed with Right Care and NHSE **Awaiting NHSE/I pack for systems bringing together all programmes e.g. GiRFT and RightCare.** **Last reviewed: November 2018 CFO** **Next review: December 2018**	Weekly Monthly Monthly Monthly	ICS CFOs ICS Unified Exec with feedback to Finance Committee and GB Programme Boards/PMO FRG meeting Finance team supported by PMO	4	4	16 ↔	NO (Schemes still being implanted with some back end loading of activity)
CATEGORY: Planned Care Programme Board		**Lead: Operations Director (SC)**										
PC1	S01, SO2, S03,SO4	There is a risk that the 62 day cancer standard at RBFT does not achieve the national standards, therefore potentially impacting on patient outcomes and experience. This may also impacts on CCG assurance ratings and NHS E funding cancer alliance transformational projects.	4	4	16	• RBFT have achieved the cancer standard for Q1. The standard has not been achieved for July and August although performance is improved as compared to July. The standard is unlikely to be achieved in September	Monthly	CCG Quality Committee ICS Quality Committee CCG Governing Body	3	4	12	Yes (but continue to monitor closely)

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			L	I	RR				L	I	RRR	Yes/No
		September 2018: inherent score revised in light of changed context, but risk wording remains the same. Source: PCPB re opened this risk at the July meeting				and hence Quarter 2. This is due to a number of factors such as the MPMRI pathway delays and delays in histo-pathology results due to a national shortage of histo-pathologists. • Recovery actions being taken by RBFT (reported to CCG Governing Body in October). • RBFT has recovered performance for 62day for October and is likely to meet the standard for November **Last reviewed: November 2018 – ICS Quality Committee, PCPB, Governing Body** **Next review: December 2018 PCPB, Governing Body, Quality Committee**						
PC5	S01, SO2	Routine Referrals to Dermatology service at RBFT **Risk added: November 2018**	5	4	20	• As a result of consultant workforce shortage, RBFT is not accepting any new routine referrals to the dermatology service effective from 30ths of November. This is likely to impact on patient experience through reduced choice and longer waiting times at our out of area acute providers. • RTT performance is likely to deteriorate further. • Patients referred prior to 30th November are going to be seen by the service. • New referrals will not have RBFT as an option on E-Referrals but patients will be able to choose an alternative provider nearby. • Dermatology Steering Group reporting into Planned Care Programme Board is	Monthly	Planned Care Programme Board	5	4	20	No (plans currently being formulated, no recovery date yet identified)

						considering options for the delivery and sustainability of dermatology in the short term and longer term.						
CATEGORY: Primary Care Commissioning Committee (PCCC)						**Lead: ACO (HC)**						
PrC2a	S01, S02	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. Source: PCCC (June 2018: Re-worded at request of Governing Body to describe risk more clearly.)	4	4	16	• 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 and link with NHSE workstreams such as international recruitment and retention. • 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. • New Primary Care Manager in post to lead this workstream. **Last reviewed: October 2017 PCCC** **Next review: December 2017 PCCC**	Quarterly	JPCCC	4	4	16 ↔	No – however BOB workstream and associated resourcing arrangements now much clearer plus additional capacity in primary care team to lead this work locally. PCCC agreed workstream now much better placed to move forward but risk rating should be left unchanged as yet to demonstrate any

												impact on primary care workforce constraints.
PrC6	SO1, SO2	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	• 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. Practices continue to experience significant and widespread issues with the service. • NHSE TV local team liaising with local NET (National Engagement Team) manager around practice specific issues. **Last reviewed: October 2017 PCCC** **Next review: December 2017 PCCC**	Monthly	PCCC	4	4	16 ↔	No – agreed Primary Care Team would work with Dr Abid Irfan as CCG Chair to send letter of concern to PCSE requesting a detailed response to issues raised (to be collated by PM representatives).

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				
		1	**2**	**3**	**4**	**5**
Likelihood	**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