West Yorkshire
Health and Care Partnership

West Yorkshire & Harrogate
Joint Committee of Clinical Commissioning Groups

Summary report			
Date of meeting: 7 June 2022		Agenda item: 14/22	
Report title:	**Risk management**		
Joint Committee sponsor:	Chair		
Clinical Lead:	Not applicable		
Author:	Stephen Gregg, Governance Lead		
Presenter:	Stephen Gregg		
Purpose of report: (why is this being brought to the Committee?)			
Decision		Comment	✓
Assurance	✓		

Executive summary

The Joint Committee has agreed an approach to reviewing and managing the risks to the delivery of its work plan. Risks are given a score of 1-5 for likelihood and 1-5 for impact. These scores are then multiplied to give the total risk score. All risks scored at 12 or above after mitigation are reported to the Committee

The significant risks to the delivery of the plan have been reviewed and are attached at **Appendix 1.** Controls, assurances and planned mitigating actions are set out for each risk. There are currently 8 risks scored at 12 or above after mitigation:

Cancer
1.1 Delivery of operational standards (Risk score - 12)
1.2 Stage shift ambition (% of patients diagnosed at stages one or two) (16)
1.3 Digital remote monitoring (12)
1.4 Workforce (15)

Mental health, learning disability and autism
3.1 Psychiatric intensive care unit (PICU) out of area placements (12)

Improving Planned care
4.2 Eye care services (16)
4.3 MSK implementation (12)

Risk 4.1 (Digital) has been reduced to 4 since the last meeting and will be removed from the register.

Urgent and Emergency
5.1 West Yorkshire Clinical Assessment Service (16). This is a **New** risk.

The risks overseen by the Joint Committee will be transferred to the ICB corporate risk register. Committees covering Finance, Investment and Performance Committee and Quality will be established to provide the ICB Board with assurance on the arrangements for mitigating and managing all relevant risks.

Recommendations and next steps

The Joint Committee is asked to:

a) **Review** the risk to delivery of its work plan and comment on the actions being taken to mitigate identified risks.
b) Note that the risks overseen by the Joint Committee will be transferred to the ICB corporate risk register

Delivering outcomes: describe how the report supports the delivery of outcomes (Health and wellbeing, care and quality, finance and efficiency)

The Joint Committee work plan focuses on the delivery of priority outcomes.

Impact assessment (please provide a brief description, or refer to the main body of the report)

Clinical outcomes:	A key element of the work plan and critical path for Joint Committee decisions.
Public involvement:	As above.
Finance:	As above.
Risk:	The refreshed risk framework is attached at Appendix 1.
Conflicts of interest:	None identified.

West Yorkshire and Harrogate Joint Committee of CCGs

Assurance Framework

Introduction

The Assurance Framework sets out how the Joint Committee will manage the principal risks to delivering agreed outcomes covered by the Committee's work plan. The Framework enables the Committee to assure itself (gain confidence, based on evidence). The framework aligns risks, key controls and assurances.

Where gaps are identified, or key controls and assurances are insufficient to reduce the risk of non-delivery, the Committee will agree the action that needs to be taken. Planned actions will enable the Committee to monitor progress in addressing gaps or weaknesses.

The Committee will:

- Monitor the principal risks that threaten the achievement of the outcomes covered by the Joint Committee's workplan.
- Evaluate the controls intended to manage these principal risks.
- Evaluate the assurance across all areas of principal risk.
- Identify positive assurances and areas where there are gaps in controls and / or assurances
- Put in place plans to take corrective action where gaps have been identified in relation to principal risks.

Risks are given a score of 1-5 for likelihood and 1-5 for impact. These scores are then multiplied to give the total risk score. The framework identifies risks with a score of 12 or more, after mitigating controls and assurances have been taken into account.

26 May 2022

Joint Committee work plan	Risk to delivery	Initial Score Likelihood x impact (Without controls)	Controls and assurances	Current Score Likelihood x impact (With controls)	Planned mitigating actions
1. Cancer Develop and agree WY&H commissioning policies impacting on cancer care, including but not limited to: • Optimal cancer pathways which deliver constitutional standards • Tele dermatology services for suspected skin cancers • Rapid diagnostic centres, best practice timed and non-site specific pathways • Personalised support for people living with and beyond cancer. • Targeted Lung Health Checks • Colon capsule endoscopy, cytosponge, and related innovations to care pathways. • Liver cancer screening and surveillance. • Non-surgical oncology.	1.1 Ability to deliver the Operational Standards within existing resources	20 (4x5)	• Planning work agreed with the Cancer Alliance Board and WYAAT Leadership. Improvement Collaborative approach across WY&H.	12 (4x3) No change	• Develop system wide plan, pathway analysis work, use of Transformation Funds and Diagnostic Capacity and Demand programme. Also, ongoing and close planning with WYAAT Leadership, focus on non-surgical oncology transformation, breast cancer diagnostic pathway and review of bowel pathway.
	1.2 Ability to deliver stage shift ambition required by the National Programme - 8% percentage points improvement shift by 2023. (Note: percentage of patients who are diagnosed with cancers at stage one or two).	25 (5x5)	• Alliance plan addressing relevant designated deliverables by the NHS Cancer Programme. • Enhanced focus on prevention, health inequalities, partnership working via Core20Plus5 programme and the remit of the Healthy Communities programme.	16 (4x4) No change since last meeting16	• Actively exploring research for evidence that additional interventions will have the desired impact. Impact of pandemic being reviewed, but noted that cancer registry data operates in arrears, so not fully possible to establish impact yet. Review of opportunities via 10-year call for evidence – national cancer strategy review. Partnership working post with Public Health focussing on addressing health inequalities.
	1.3 The lack of a digital remote monitoring system to track patients on a personalised stratified follow up pathway presents a significant risk to both patient safety, with reliance on manual spreadsheets to monitor patients and a lack of effective safety-netting, and progress against the national deliverables; without a robust digital system, progress on PSFU will stall as pathways are agreed but are unable to be implemented safely.	25 (5x5)	• Continued support from Macmillan Implementation Project Managers, working to support Trusts to find suitable solutions and sharing best practice. Discussions ongoing through the Living With and Beyond Cancer Project Group to share learning and approaches. Focus on transforming outpatients provides an opportunity to connect to this work and align with cancer and the local digital roadmap, ensuring optimisation of RMS technology across several specialities within the Trust. Discussion with Chief Information Officers and inclusion of the risk on provider risk registers.	12 (3x4) Reduced from 16 since last meeting	• Working with Outpatient Transformation programme to align priorities and share learning. Practical support provided through Implementation Project Managers to identify solutions / workarounds. Regular calls with national cancer team who have escalated this to Region. • Work with external consultancy on RMS solutions, report due by the end of Q1, which will enable a business case to be developed at each provider trust, with an implementation timescale. Noted that Harrogate have an implementation plan for Somerset Cancer Registry – from July, opportunity to share learnings across the ICS.

	1.4 Cancer Workforce plan affecting the capacity to deliver the optimal pathways as required by NHS England (lung, colorectal and prostate) and other priorities including non-surgical oncology.	15 (5x3)	• Re-testing the data and underpinning assumptions each of the pathway workstreams.	15 (5x3) No change since last meeting	• Working with Health Education England actively and the ICS/H&CP workforce group (as well as the Local Workforce Action Board). .• Appointment of an HEE funded cancer workforce lead for WY&H. • Influencing content of the forthcoming NHS People Plan through system leaders. • Actively looking at skill mix as part of system work on non-surgical oncology and diagnostics, including at Regional level. • Support for ACP and non-medical consultant posts for non-surgical oncology services.
2. Maternity Agree the approach to commissioning maternity services across WY&H including: • the specification, service standards and commissioning policy. • the commissioning and procurement approach	• No relevant risks currently scored at 12 or above.				
3. Mental Health, learning disability and autism • Agree a single operating model for the management of acute and psychiatric intensive care unit (PICU) beds. • Agree a standard commissioning approach to acute and PICU services and a commitment to peer review local crisis services. • Agree plan for the provision of children and young people inpatient units, integrated with local pathways. • Agree a collaborative commissioning model for Assessment and Treatment Units across West Yorkshire for people with learning disabilities to support the new operating model.	3.1 There is a reputational and quality risk that the number of PICU out of area placements continues to grow across the ICS, leading to poorer patient experience and increased scrutiny by NHS England/Improvement. At present this risk is heightened by the presence of covid.	20 (4x5)	• Secondary Care Pathways steering group is a formal workstream of the programme and has PICU as a component part with steering group, clinical leadership and SRO. • Weekly 'cohorting' and mutual aid discussions between the MHLDA collaborative • Regular submissions on out of area placements to MHLDA core team and NHS England	12 (4x3) No change since last meeting	• Continue to build on the modelling work undertaken by NICHE consultancy to progress opportunities for closer system working and future capacity needs, including revising the modelling post-pandemic. • Appointment of Senior Inpatient Oversight Lead role on behalf of the MHLDA collaborative to support discussions re bed pressures across the system. • Co-production work to understand impact on service users of OAPs and our ability to deliver continuity of care principles • Use outputs from Community Mental Health Mapping exercise to inform community improvements as upstream interventions to reduce reliance on inpatient services • Align the CMHT Transformation project to the wider demand agenda, making the dependencies clear

4. Improving Planned care Develop and agree WY&H commissioning policies, including, but not limited to: • Clinical thresholds and procedures of low clinical value; • Efficient prescribing. Develop and agree service specifications, service standards and the commissioning and procurement approach to support pathway optimisation, including outpatients transformation	4.2 There is a need for disproportionate investment in eye care services over the next 5 years to meet increasing growth in demand. This will require investment in hospital and community eye services. Without this investment growth will not keep pace with demand and people will be at risk of preventable sight loss.	20 (4 x 5)	• Raise awareness through programme working groups including programme board, through shared leadership arrangements with WYAAT, and through WY&H Finance Forum. Bradford and Wakefield are already planning for now. Places need to consider planning for the growth in demand over the next 5 years.	16 (4 x 4) No change since last meeting	• Through implementation planning ensure need for additional investment is highlighted and escalated within organisations. Meeting of programme directors with Place based planned care arranged by NHSE/I regional director. Confidence that current spending plans will reflect this. There is an increased risk from COVID 19 that implementation planning in eye care services will be delayed.
	4..3 There is a need for clear plans for MSK implementation at place to reflect demographic growth and shift in investment to preventative and conservative management strategies. Without investment in MSK services secondary care demand will continue to grow. We want to stem the rate of growth.	16 (4 x 4)	• Raise awareness through programme working groups including programme board, through shared leadership arrangements with WYAAT, and through WY&H Finance Forum, and highlight the impact on the delivery of our programme.	12 (4 x 3) No change since last meeting	• Through implementation planning ensure need for additional investment is highlighted and escalated within organisations. Investment strategy to reflect future intentions. There is an increased risk from COVID 19 that implementation of the MSK pathway and the suite of MSK commissioning policies will be delayed.

Improving planned care	4.4 Technological advancement not progressing at the same pace as the programme to enable standardisation of commissioning policies and clinical thresholds and care pathways to be implemented at pace to deliver the identified outcomes, and achieve the realisable benefits within the programme's deliverables. This programme does not have the financial resource to support the creation of additional capacity.	20 (5 x 5)	• Ensure integration and collaboration with Digital programme of WYH HCP. Digitally enabling our population to engage with the programme: ensuring we include patient facing digitisation of the programme in collaboration with the digital programme of WYH HCP. • As part of the transition work to establish the WY ICB a process of alignment of policies, and the IFR process itself is being undertaken. • The digitisation of patient care interfaces has progressed at pace as a result of the SARS-Covid19 pandemic from 2019 – 2022. All NHS secondary care providers are now significantly advanced in their digital and tech implementation. Aspects relating to access and risk of inequity of access are being monitored and addressed through the WY Digital Programme.	4 (2x2) Reduced from 12 since last meeting	• Engaging with primary care and secondary providers to identify gaps in technological advancement • Encouraging and engaging participation from technology advancement leads across the provider and commissioner sectors to support development of digital platforms to aid clinicians in directing patients along elective care pathways and in shared decision making with patients • Engaging with and working with NHS England, NHS Improvement and NHS Digital to address the gaps in technology or technological ability or functionality issues experienced by providers within the scope of the programme • WYAAT engagement • Link with NHS Digital – ERS • Trial in the ERS and ophthalmology referrals for optometrists via NHS Digital. • Procured eRS platform for ophthalmology in December 2021 with funding and support from NHSX and NHSE/I with implementation to commence in March/April 2022. Will enable transmission of images and Advice and Guidance between community optometry and secondary care ophthalmology departments, with the aim of managing patients safely in community, plus with updated guidance from the Royal College of Ophthalmology to manage low risk post cataract procedure patients being managed in community with NOD data submitted by community optometrists to NHS Digital: supporting technological advancement in eye care. Need to evaluate outcomes and benefits in 6 to 12 months. • The programme director has become a member of the Digital Programme Board and the programme works collaboratively with the WYH HCP Digital Programme to explore the digital needs of the Improving Planned Care Programme. • EeRs implementation is progressing, funded and supported by NHSEI regional team • WY IFR process is in development and for discussion at Future Transition Group in June 2022 • Alignment of first tranche of policies complete. Second tranche due at JCC in June 2022. • A small number of procedures remain which require alignment, but this group represents a low risk to the CCGs / ICB and work is underway to complete these. • Numerous medicines policies still require alignment. Responsibility for medicine policies has been transferred to the Pharmacy function

					of the Clinical and Professional Directorate of the Shadow ICB, which will continue to progress this work.
5. Urgent and emergency care • For Integrated Urgent Care and 999 services, agree for WY&H the transformational, finance and contractual matters identified as CCG decisions to be made in collaboration across Yorkshire and the Humber. • Agree the specification, business case, commissioning and procurement process for GP out of hours services	5.1 Additional funding is required for NHS 111 increased demand for call handling and clinical capacity along with local WY Clinical Assessment Service provided by LCD.	16 (4 x 4)	• Mitigated through NHSE/I SDF and capacity funding in 2021/22 • Increased demand in NHS 111 is resulting in call queues and matching staff capacity with increased demand is challenging. • Development of WY Clinical Advice Hub has increased referrals outside of YAS into a WY clinical assessment resource.	16 (4 x 4) New risk	• National funding for NHS 111 in 2022/23, is being offered subject to provider readiness to embrace new telephony system. However, no national funding is identified for local CAS which is currently provided by LCD. • At present the current funding envelope covers local CAS for limited time (by Q1 of 2022-23) • A joint Task & Finish group is established to discuss and agree short, intermediate and long term model of local CAS however all places (CCGs) UC leads agree CAS provision as a priority for WY ICB. • Local CAS model will be developed through the work of Task & Finish group and inform funding requirement for 2022-23
6. Joint Committee decision-making • Joint Committee decisions are robust, with appropriate public and patient involvement, clinical engagement and quality assurance.	• No relevant risks currently scored at 12 or above.				