West Yorkshire and Harrogate
Health and Care Partnership

West Yorkshire & Harrogate
Joint Committee of Clinical Commissioning Groups

Summary report			
Date of meeting: 6th July 2021		Agenda item: 29/21	
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 7 risks scored at 12 or above after mitigation:

Cancer
1.1 Impact of COVID19 on diagnostic capacity (risk score – 12)

Maternity
2.1 Development of a Maternal Medicine Network across Yorkshire & Humber (12)

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

Improving Planned care
4.1 Hydroxychloroquinine monitoring (12)
4.4 Eye care services (16)
4.5 MSK implementation (12)
4.6 Digital (12)

Two risks will be removed from the register after this meeting, as the risk level is now below 12:

Risk 4.2 Workforce - reduced to 6 since the last meeting.
Risk 4.3 Flash glucose monitoring – reduced to 3 since the last meeting.

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.	
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.

Appendix 1

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.

29th June 2021.

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: • Lynch syndrome testing • Optimal cancer pathways which deliver Constitutional standards • Tele dermatology services for suspected skin cancers • Rapid diagnostic centres • Personalised support for people living with and beyond cancer	1.1 The impact of COVID19 has reduced patient presentation with symptoms and capacity constraints have, and continue to extend waiting times. Risk assessment and prioritisation of cancer care mean the principal risks are delayed diagnosis leading to poorer survival outcomes, and inability to deliver NHS Constitutional standards. Delivering earlier diagnosis of cancer is one of the 10 big ambitions for the H&C Partnership	20 (5x4)	• Well established and functional Cancer Alliance Board • Well established, regular and robust relationships with WYAAT stakeholders • Regular data analysis and modelling to understand impact • Clear national strategy and prioritisation of cancer care • Commitment from WYAAT providers to protect and continue to prioritise capacity for time critical cancer care.	12 (3x4) No change since last meeting	• System-wide priorities agreed to align efforts of all stakeholders around recovery of referrals and maximisation of capacity for diagnosis and treatment. • Collection and ongoing analysis of data to understand 'missing' referrals and target encouragement to present where appropriate. • Investment of Alliance SDF in supporting programme of innovation implementation to aid case finding and clinical risk stratification to make best use of available capacity. Subject to impact assessment this may require consideration for business as usual. • Collaborative programme with Planned Care Alliance on key diagnostic capacity and demand.
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	2.1 Development of a Maternal Medicine Network across Yorkshire & Humber. The three LMS's have been identified as leads on this project .The national service specification is still in draft and the commissioning arrangements are challenging. The service will not be in place by 1st April 2021	16 (4x4)	• Funding in CCG baseline. • Agreement with South Yorkshire and Bassetlaw and Humber Coast and Vale that one ICS/CCG will take responsibility for commissioning regional provision..	12 (3x4) Reduced from 16 since last meeting.	• Meeting held with the regional maternity team and obstetric staff across the system 10.06.21.. • Regional team commissioning a project officer for 6 months. • Collaboration continues across the system.

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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 • Utilise short-term 'step up' capacity within the independent sector in West Yorkshire for managing out of area placements • Use the forthcoming demand and capacity modelling tool to understand future inpatient demand across WY. • 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

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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	4.1 Hydroxychloroquine: There is a cohort of people prescribed and taking Hydroxychloroquine/ chloroquine in the community across WY&H who are not being monitored to guard against the risk of avoidable sight loss. The ICS currently doesn't have an effective monitoring programme, and this will continue if the ICS does not commission a service to deliver one; heightening the risk of sight loss to people across WY&H. The capacity challenges faced by providers add to the difficulty in providing a service to monitor patients, and capacity challenges will present difficulty in having enough suitably qualified staff.	15 (5 x 3)	• A monitoring protocol follows issued guidance from the Royal College of Ophthalmologists	12 (4 x 3) No change since last meeting	• There will be local negotiations with NHS providers to see if something can be delivered within Hospital Eyecare Services. We will need to consider a System option if there's no success with this. There needs to be a relationship between hospital eye care services and the community to build capacity. The programme's plan to manage AMD, Cataracts and Glaucoma and eventually Diabetic Retinopathy demand for services will create capacity in the system in ensuring appropriate referrals and streamlining the discharge and follow up pathway and process to ensure that only appropriate patients are seen in outpatients. The pathway and policy were agreed at JCC in November 2019. An implementation meeting is planned for Q4 with a 3 year implementation plan. 1 place is ready to implement from 1 April 2020.
Improving planned care	4.2 There is a risk that transformational changes cannot be implemented (subject to outcome of consultation with key stakeholders) due to lack of available & appropriately skilled workforce or the current workforce unwilling to adapt to changes in working or to upskill to address any skills gap. This will affect the implementation of the WY&H MSK Pathway that has a target implementation period of 3 years and associated MSK policies have a period of 1 year. Without the appropriately skilled staff to deliver the services along the MSK pathway these implementation dates will not be met.	15 (3 x 5)	• Workforce information will need to be collected as part of the programme and a defined plan and strategy to work with the West Yorkshire & Harrogate Workforce Strategy Group to address workforce challenges. • Explicit mitigation action with LWAB to escalate the risk of the system being able to roll out FCPs to 15% of the population by 2020 against the risk of de-stabilising the system. • The role and uptake of FCPs and Pharmacists in Primary care networks will present challenges at Place and for LWAB to take responsibility where physiotherapists are taken from elsewhere in the system.	6 (2 x 3) Reduced from 12 since last meeting	• To maintain all other services, staff will need to be upskilled and Primary care networks will need to fund and develop these new roles. There is a need for a conversation with the primary and community care programme. Work with Health Education England (HEE) to proactively identify training needs and opportunities to develop workforce across different workstreams • Workforce development is needed and to bring to attention of HEE (revised partnership workforce) • Local Workforce Action Board – work with and identify skills gap and strategies to address. • Engage with workforce, Comms and Engagement Manager (internal comms strategy). Bid for first contact practitioners (FCP) implementation from LWAB across the ICS in June 2019, and primary and community pharmacists and optometrists' development: the biggest risk to the future sustainability of this programme. The outcome of the bid for FCP implementation received in August 2019 with £50k received. • Other sources of funding to be researched with NHSE and the Primary and Community

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					Programme across WY&H. We need to provide whatever support we can for our Places to be in a position to implement the MSK pathway and associated policies. • To support the eye care programme HEE are undertaking a workforce census in WY&H. in addition HEE will explore best practice in workforce models for dermatology and compare WY&H with good practice nationally. • Two cohorts of FCP development have been delivered through University of Bradford and further funding for a third cohort agreed. FCP posts agreed in majority of PCNs with majority now in post. We have more than 80% coverage of FCP provision for the WY&H population. Project now moving to business as usual. • Funding agreed through HEE for optometrist development with postgrad qualifications in key specialities of glaucoma and medical retina. Further funded training places agreed for current year. Further workforce development would be desirable but is sufficient to support nay left shift of activity to prevent avoidable referral to secondary care or support long term condition management.
Improving planned care	4.3 Flash Glucose monitoring prescribing levels	15 (5 x 3)	• Our whole system spend on Flash is almost £3m per year and has increased significantly over the two years that it has been available (2018/19 20k; 2019/20 £1.2m). We have not seen any noticeable change in Blood Glucose Testing Strips spend, suggesting the predicted offset has not materialised, but without audit data it is not possible to make comparisons between people with / without flash to see whether there has been a reduction in the flash group.	3 (1 x 3) Reduced from 12 since the last meeting	• We expect spend on Flash to continue to increase over the coming years. We cannot predict what the rate of increase will be but do not expect it to be as steep as over the past two years.
Improving planned care	4.4 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	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	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

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	pace with demand and people will be at risk of preventable sight loss.		planning for now. Places need to consider planning for the growth in demand over the next 5 years.		COVID 19 that implementation planning in eye care services will be delayed.
Improving planned care	4.5 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	4.6 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.	12 (3 x 4) No change 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. • 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.

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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	• No relevant risks currently scored at 12 or above.				
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.				