West Yorkshire & Harrogate
Joint Committee of Clinical Commissioning Groups

Summary report			
Date of meeting: 2 July 2019	Agenda item: 42/19		
Report title:	**Joint Committee risk management**		
Joint Committee sponsor:	Marie Burnham, Independent Lay Chair		
Clinical Lead:	N/A		
Author:	Stephen Gregg, Governance Lead		
Presenter:	Stephen Gregg		
Purpose of report: (why is this being brought to the Committee?)			
Decision		Comment	✓
Assurance	✓		

Executive summary

Risk management

1. The Joint Committee has agreed an approach to reviewing and managing the risks to the delivery of its work plan. All relevant risks scored at 12 or above *after mitigation* are reported to the Committee. The updated risk framework as at 25th June 2019, is attached at **Appendix A.** Controls, assurances and planned mitigating actions are set out for all risks. There are currently 5 risks scored at 12 or above after mitigation:

   Urgent and emergency care
   5.1 IT, interoperability and issues with national system

   Elective care/standardisation of commissioning policies
   6.1 Potential resistance to proposed changes.
   6.2 Financial return.
   6.3 Clinical leadership.
   6.4 Workforce.

Recommendations and next steps

The Joint Committee is recommended to:

- **Review** the risk management framework and **comment** on the actions being taken to mitigate the risks identified.

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

Effective risk arrangements are needed to ensure the delivery of the Joint Committee work plan.

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

Clinical outcomes:	See risks set out at Appendix A.
Public involvement:	See risks set out at Appendix A.
Finance:	See risks set out at Appendix A.
Risk:	Significant risks are attached at Appendix A.
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 STP 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.

Appendix A

Summary of risks 29.04.19

STP outcome covered by work plan	Risk to delivering the outcome	Initial Score Likelihood x impact (Without controls)	Controls and assurances	Current Score Likelihood x impact (With controls)	Planned mitigating actions
1. 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.				
2. Cancer • New strategic approaches to commissioning and providing cancer care.	• No relevant risks currently scored at 12 or above.				
3. Mental Health • 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.	• No relevant risks currently scored at 12 or above.				

STP outcome covered by work plan	Risk to delivering the outcome	Initial Score Likelihood x impact (Without controls)	Controls and assurances	Current Score Likelihood x impact (With controls)	Planned mitigating actions
4. Urgent and emergency care Integrated urgent care services • Agree the specification and business case (incorporating future arrangements for NHS 111 and GP out of hours services). • Agree the commissioning and procurement process to deliver services from 2019 onwards.	4.1 There is insufficient resource to deliver on IT and interoperability and issues remain with national systems	16 (4 x 4)	• Urgent and emergency care IT Leadership. • Well established links with NHS Digital, NHS England and NHS Improvement. • Agreed escalation with NHSE/NHS Digital.	12 (3 x 4) (No change since last Joint Committee)	• Engagement with CCGs and local places to connect systems. • "GP Connect" pilot will provide better interoperability if proved successful. This is currently being tested in Leeds and initial results are positive. This should resolve interoperability issues, significantly reduce the need for additional resources to configure local practices and significantly reduce the risk.
5. Elective Care/standardisation of commissioning policies Develop and agree commissioning policies, including: • Pre-surgery optimisation (supporting healthier choices); • Clinical thresholds and procedures of low clinical value; • Eliminating unnecessary follow-ups; • Efficient prescribing.	6.1 There might be resistance to some of the proposed changes from commissioners and other stakeholders (e.g. politicians, the public). Communicating the change and People's perception of the programme and its workstreams, and addressing Patients' and Public fear of privatisation of the NHS and perception of rationing patients' access to health care services portrayed through Public Relations and Social Media, for example that forms their perception of the programme.	20 (5 x 4)	• Develop a strong stakeholder management approach as part of the comms & engagement strategy • Consider the need for consultation and type of consultation where there are significant service changes required. • Getting the narrative right and engaging with our communities as soon as possible • Implementing our communication and engagement strategy within set deadlines and timelines, and consider defined resource to focus on public relations of the programme • Utilising the programme board as a test board for actions and means to develop mitigating strategies.	16 (4 x 4) (No change since last Joint Committee)	• Proactive communications and engagement. Participation of lay members in programme board to ensure lay perspective is considered throughout • Lay representation on Clinical Thresholds and need to increase people and public participation in the Working Group • Charity involvement and need to do more. Recruited Comms and Engagement manager to support programme • The programme's narrative has been agreed and is now on the WYH HCP website so people are assured on our aims and objectives and how this programme may affect them • Communications lead in the partnership and the engagement manager working on our Communications and Engagement strategy • Linking our charity engagement to our work with the Institute for Voluntary Action Research (IVAR) and WYAAT's (West Yorkshire Association of Acute Trusts) patient education project. • Questions put to the programme at January 2019 Joint Committee session assures that people are engaging with the programme and its leadership is good at handling communications around the programme's deliverables. • Do Once and Share learning sets meetings and conversations with the CCG Accountable Officers

STP outcome covered by work plan	Risk to delivering the outcome	Initial Score Likelihood x impact (Without controls)	Controls and assurances	Current Score Likelihood x impact (With controls)	Planned mitigating actions
					are in place. Will meet regularly to engage our partners with the programme and the work needed to be done, and to ensure we deliver on our aims and objectives. This demonstrates we have a 'party line' and our workforce will stick to it.
Elective are/standardisation of commissioning policies (cont.)	6.2 Financial return and impatience. This is a long game.	20 (5 x 4)	• Efficiency savings will be achieved in implementing changes in clinical thresholds and care pathways that will release capacity and resource to be applied elsewhere in the system. • It will take time for transformation of a systems approach and application of standardised policies to deliver efficiency savings to measure the financial gains across WY&H.	12 (4 x 3) (No change since last Joint Committee))	• PwC resource in Summer 2018 quantified some of our financial gains to be delivered through the programme. • Recognise that financial benefit will primarily come from future cost containment, rather than actual reduction in spend. • This will be achieved through demand reduction through supporting healthier choices, and implementation of efficient and clinically effective pathways and policies. • Approved suite of policies to mitigate cost and changed conversation as regards 'the conversation' on freeing costs
	6.3 Clinical Leadership and creating a movement for change	20 (5 x 4)	• Clinicians will need to be bought in to the movement of change and have an appetite for it otherwise the benefits to be achieved from this programme will not be realised. • Engagement and consultation with clinicians will need to commence as soon as possible to ensure the programme achieves its deliverables at the relevant milestones. • Clinical consultation will be vital in determining a list of procedures of	12 (4 x 3) (No change since last Joint Committee)	• Changing the conversation at locality and Place based level. Using the conversation about Referral to Treatment and 52 weeks to start the conversation about the programme. • Consulting with the Clinical Forum in seeking steer and governance in revising procedures of limited clinical value, redesigning care pathways and in reviewing commissioning policies, and when encountering resistance from clinicians to the movement for change. • Active engagement from WYAAT clinicians on Musculoskeletal and elective orthopaedics, and developing strategy for engagement with primary and community sector. • Programme has established the Joint Elective

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Elective are/standardisation of commissioning policies (cont.)			limited clinical value and agreeing revised care pathways for elective care procedures, as well as the work to be done on supporting healthier choices and the further work to be done on prescribing.		Surgery Leadership group with WYAAT and 'Leading the Way' newsletter following the Planned Care Leads event in November 2018. Added to by the Eye Care Services event in November 2018 building on the work of NHS England and NHS Improvement Getting it Right First Time and Rightcare teams looking at the capacity and demand for eye health services across WY&H.
Elective are/standardisation of commissioning policies (cont.)	6.4 Transformational changes may not be implemented 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.	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 Local Workforce Action Board (LWAB) to escalate the risk of the system being able to roll out First Contact Practitioners (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.	12 (3 x 4) (new risk from last Joint Committee)	• 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) • LWAB – work with and identify skills gap and strategies to address • Engage with workforce, Comms and Engagement Manager (internal comms strategy)