West Yorkshire and Harrogate Health and Care Partnership

West Yorkshire & Harrogate
Joint Committee of Clinical Commissioning Groups

Summary report			
Date of meeting: 1 October 2019	Agenda item: 52/19		
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. 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 relevant risks scored at 12 or above *after mitigation* are reported to the Committee.

2. Risks as at 24th September 2019 are attached at **Appendix A.** Controls, assurances and planned mitigating actions are set out for each risk. There are currently 5 risks scored at 12 or above after mitigation:

   Urgent and emergency care
   4.1 IT, interoperability and issues with national systems (risk score – 12)

   Elective care/standardisation of commissioning policies (SCP)
   5.2 Financial return (12)
   5.4 Workforce (12)
   5.5 Sustainability of the programme (15)
   5.6 Avoidable sight loss (15)

   Risks 4.1, 5.2 and 5.4 have previously been reported to the Joint Committee. Risks 5.5 and 5.6 have been added to the register since the Joint Committee last met in July 2019.

3. The scores for 2 Elective care/SCP programme risks have been reduced to below 12 since July. These risks are shown on the register, but will be removed from future versions:

   5.1 Potential resistance to proposed changes (now scored at 9).
   5.3 Clinical leadership (now scored at 9)

Recommendations and next steps

The Joint Committee is recommended to:

a) **review** the risk management framework and **comment** on the actions being taken to mitigate current risks.

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 Appendix A.
Public involvement:	See Appendix A.
Finance:	See Appendix A.
Risk:	See 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.

Summary of risks 24.09.19

Appendix A

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.				

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 July 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.	5.1 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.	9 (3 x 3) (Score reduced from 4x4 since July Joint Committee – risk will be removed)	• 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.

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					• Do Once and Share learning sets meetings and conversations with the CCG Accountable Officers 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 Care/standardisation of commissioning policies (cont.)	5.2 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. We need to focus on the long term gains such as the savings to be made from NHSE's evidence based interventions and adopting a policy across WY&H on low value prescribing in primary care.	12 (4 x 3) (No change since July 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 • We now have strong financial leadership in the programme and commitment in place for better financial management looking at cost calculation and improvement. We anticipate that during the latter part of 2019/20 we will deliver some analysis on costs and gains, and identification of unmet need (health equity) cost to the programme.
	5.3 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.	9 (3 x 3) (Score reduced from 4x3 since July Joint Committee – risk will now be removed)	• 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.

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
Elective Care/standardisation of commissioning policies (cont.)			• Clinical consultation will be vital in determining a list of procedures of 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.		• Programme has established the Joint Elective 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 Care/standardisation of commissioning policies	5.4 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.	12 (3 x 4) Risk score unchanged since July Joint Committee. Risk description amended and mitigating actions revised.	• 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 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.

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
Elective Care/standardisation of commissioning policies (cont.)	5.5 Sustainability of the programme. The programme team is funded through non-recurrent funding. At present there is no clear source of funding programme staff and operating costs in 2020-21; anticipated funding sources/levels are likely to be significantly reduced on previous years.	25 (5 x 5) New risk.	• Risks will be mitigated by the following: SRO, Programme Director, Project Manager , Programme Support Officer, Workstream Oversight Group and Working Groups for the different workstreams. Regular progress reports and strong programme management will highlight risks to delivery and measures to address and mitigate them. Either we accept the context of our programme is reframed as per our capacity or this programme is immune from the reality as were are demonstrating our value across our programme: a choice needs to be made by the ICS (Joint Committee) or SOAG, e.g. people need easy read versions of our materials and we need to engage people in what we are doing but we don't have the funding and resources to do these things. If we don't resolve these risks, they escalate and we're unable to mitigate, i.e. continually increasing. • Conversations to be had with WYAAT colleagues to provide funding for the post of programme manager to ensure joined up delivery across WYH HCP and WYAAT beyond 2020 to achieve the deliverables of this programme and its eye care workstream. Develop agreement across the HCP about maintaining the position we achieve, ensuring an ongoing legacy.	15 (3 x 5) New risk.	• Performance management of planned care functions will track the achievement of key deliverables and alignment of programme resources; highlighting risks and identifying the realisation of benefits. The changing deliverables of the programme may increase pre and post mitigation scores and impact dependent on the expectation of the programme, e.g. System Oversight and Assurance Group (SOAG). The programme leadership will discuss funding with NHS England and NHS Improvement colleagues; the WY&H HCP has commenced discussions about establishing a more sustainable approach to funding; in the longer term the programme staffing costs may decrease if places truly adopt a Do Once and Share Approach to delivering the planned care programme. The programme leadership cannot manage this risk entirely within the programme.

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
Elective Care/standardisation of commissioning policies (cont.)	5.6 That there is a cohort of people prescribed and taking Hydroxychloroquine in the community across WY&H who are not being monitored to guard against the risk of avoidable sight loss. The CCGs of WY&H do not currently have services commissioned to provide monitoring.	15 (5 x 3) New risk	• Heads of medicines management currently have identified this as a risk at their relevant Places. The Elective Care and SCP programme has developed a pathway for the WY&H HCP which has clinical approval. This should be brought to JCC for decision in November 2019.	12 (4 x 3) New risk	• The collective risk of the programme and the ICS in conjunction with the WY&H Pharmacy Leadership Group has been assessed. It is unclear whether the capacity exists to provide this service within existing capacity / resources in the WY&H Hospital Eye Services. Places will assess the feasibility of this and consider system-wide approaches to delivery if required.