Date:	8 December 2016
Meeting:	Governing Body
Item Number:	Item 8.4
Public/Private:	Public ☒

Author: *(Name, Title)*	John Pougher, Head of Governance
GB Lead: *(Name, Title)*	Catherine Wylie, Director of Nursing & Quality

Report Title:
Governing Body Assurance Framework
Decisions to be made:
To note and approve

Continue to improve the quality of services	☒	**Improve patient experience**	☐
Reduced unwarranted variations in services	☐	**Reduce the inequalities gap in North Lincolnshire**	☐
Deliver the best outcomes for every patient	☐	**Statutory/Regulatory**	☒

Executive Summary (Question, Options, Recommendations):

To inform the Governing Body of the risks to the delivery of North Lincolnshire CCG (NL CCG) strategic objectives and risks.

The Assurance Framework provides a structure and process that enables the organisation to focus on those risks that might compromise achieving its most important (principal) objectives; and to map out both the key controls that should be in place to manage those objectives and confirm the Audit Group has gained sufficient assurance about the effectiveness of these controls.

In line with NL Risk Management Strategy all other identified risks are held on the Directorate Risk Registers. Work is on-going to ensure that risks, including partnership risks, continue to be captured and managed at the appropriate level.

The risks are presented in a format that includes a risk tolerance score and a tracker chart. The format will be developed in light of feedback, requirements of the CCG and best practice guidance. In addition the scoring matrix and severity guide taken from the CCGs Risk Management Strategy have been attached to help inform the Quality Groups review of the identified risks.

Equality Impact	Yes ☐ No ☒	
Sustainability	Yes ☐ No ☒	
Risk	Yes ☒ No ☐	The AF is a key element of the organisations corporate governance framework.
Legal	Yes ☒ No ☐	The organisation needs to demonstrate that it has an effective system to identify and manage risks
Finance	Yes ☐ No ☒	

Patient, Public, Clinical and Stakeholder Engagement to date									
	N/A	***Y***	***N***	***Date***		***N/A***	***Y***	***N***	***Date***
Patient:	☐	☐	☒		**Clinical:**	☐	☐	☒	
Public:	☐	☐	☒		**Other: Exec Team**	☐	☒	☐	30.11.16

Summary of NL CCG Board Assurance Framework Risks

Risk AO1: Breakdown in productive relationship with key partners would compromise the delivery of all CCG objectives: Risk Rating **8**

Risk F1: If the CCG fails to deliver a balanced budget there will be no resources to support investment and the CCG could lose ability to self-direct from NHS England: Risk Rating **20**

Risk PC1: Lack of accurate data on out of hospital mortality may result in areas of high risk not being identified or addressed: Risk Rating **12**

Risk PC2: Inability to recruit sufficient GPs and nurses could lead to difficulty maintaining current level of service and quality outcomes for patients: Risk Rating **20**

Risk PC3**:** Medicines Management programme will not deliver planned QIPP savings for 2016/17: Risk Rating 20

Risk PC4: If ACP is not effectively established there will be a failure to make quality improvements, maximise financial benefits and move services into the community ultimately leading to a failure in our 'place' response to HLHF. Risk Rating 15

Risk Q4: Risk to CCG regarding delayed delivery of retrospective claims: Risk Rating **9**

NL CCG Strategic Objectives

A. Continue to improve the quality of services

B. Reduce unwarranted variations in services

C. Deliver the best outcomes for every patient

D. Improve patient experience

E. Reduce the inequalities gap in North Lincolnshire

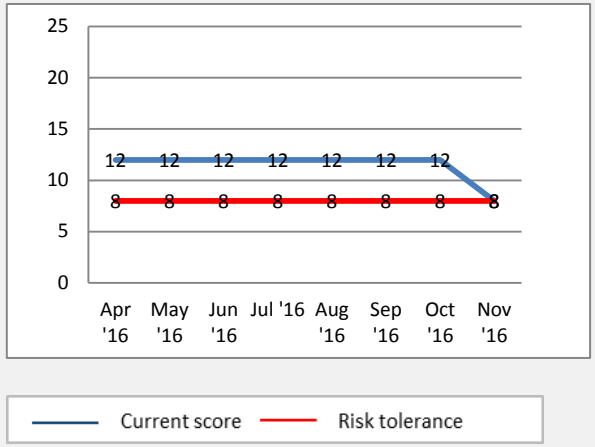
Risk AO1: Breakdown in productive relationship with key partners would compromise the delivery of all CCG objectives	**Lead Director/risk owner: Accountable Officer**
Strategic Objective – links to all strategic objectives	**Date of last review**: 1.12.16

Controls (what mitigating actions are being taken):	**Actions**	**Owner**	**Due date**
CCG structures and committees reviewed to ensure their effective utilisation Council of Members operating in a new form Working with Chair of Health and Wellbeing Board and support team to agree productive partnerships Interim shared governance arrangements and integrated working with N Lincs LA established Structure and processes and partnership working with Health Lives Healthy Futures (HLHF) including independent chair established Through HLHF the CCG has a community finance approach and Memorandum of Understanding Established agreed set of principles to support partnership working Established AO to Chief Exec/equivalent regular 1:1s with key providers and LA STP MOU and Joint Commissioning Committee established	Work with Health Wellbeing Board to agree provider partnership strategy for the year Develop more integrated problem solving approach Develop next stage integrated governance and reporting (with GGI) Develop integrated commissioning approach – workshop Jan 17	AO AO DNQ AO	Sept 2016 Sept 2016 complete Feb 17 Feb 17

Gaps in Controls - None

Assurances (how do we know if the things we are doing are having an impact?):	**Gaps in assurances** (what additional assurances should we seek?):
Community finance plan. HLHF MoU and ToR Either NLCCG AO or NLC Chief Exec can represent each other in AT SCALE work	

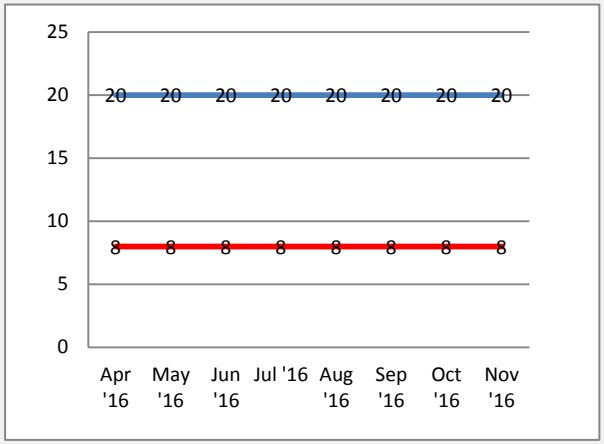
Risk Rating
Impact 4
Likelihood 2
Current Score:
4 x 2 = 8
Risk tolerance:
4x 2 = 8
Source of Risk:
Stress due to financial challenges across the system
Pace of change and competing priorities



Reasons for current risk score:
Impact score 4 as without these productive relationships the CCG will be unable to achieve financial stability.
Likelihood score 2 due to increasing stability following recent changes

Rational for risk tolerance score:
Score 8 (consequence 4 likelihood 2)
Consequence will continue to be 4 but a likely score of 2 reflects the challenges inherent in this risk

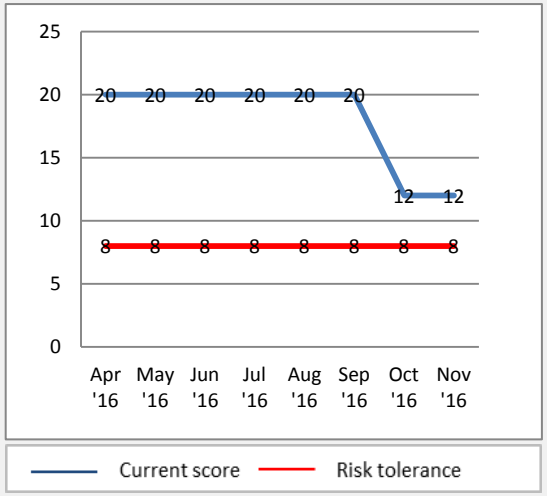
Additional comments
Significant amount of work undertaken over the past few months has resulted in the anticipated trajectory to move in a positive direction

Risk F1 If the CCG fails to deliver a balanced budget there will be no resources to support investment and the CCG could lose ability to self-direct from NHS England (direct intervention)		**Lead Director/risk owner: CFO**	
Strategic Objective A		**Date of last review**: 01.12.16	
Controls (what mitigating actions are being taken): Financial controls, regular meetings with budget holders. QIPP monitoring, Contract monitoring. Finance & Performance Group. Financial Control Environmental Assessment.	**Actions** New operational group in place including, Transformation Group, Planning and Oversight, Contract Management Group Exec chaired sub-teams include: Demand Management, Prescribing, Urgent Care, Technical Contract/Finance Recovery Plan to NHSE, NHSE Review of Forecast, NHSE involved in some review meetings, Internal audit review in second half of year, Engine Room engagement	**Owner** CFO	**Due date** On-going to April 2017
Gaps in Controls Resulting from the move to a more formal PBR contract with NLaG (as opposed to the MoU based contract in 2015/16) implementation of first months formal reporting			
Assurances (how do we know if the things we are doing are having an impact?): CCG Engine Room and Governing Body monitor. Monitoring information is also added to BIZ. Audit Group monitors adequacy of controls. Standard Checklist for Budget Holder meetings. The BCF metrics and finances are also reported to joint meetings with the Council & to NHS England, at least quarterly. External Audit Value for Money Reports. Deloitte assurance report available to CCG and their auditors. NHSE QIPP review process, Regional QIPP monitoring reports to CCG. Independent review on CHC spend. Underlying position reported to NHS England and included in Board Report. CCG assurance process includes finance (assured with support). MOU and various risk shares helps to minimise financial risk in 16/17.		**Gaps in assurances** (what additional assurances should we seek?): QIPP plan being reviewed. From period 3 16/17 the CCG will be reporting an underlying deficit to NHS England – Forecast changed at M7 to reflect £2m deficit – further risk highlighted in QIPP programme.	
Risk Rating likelihood 4 impact 5 **Current Score:** 20 **Risk tolerance:** 4 x 2 = 8 **Source of Risk:** Finance and performance data		**Reasons for current risk score:** Impact – risk to corporate autonomy Likelihood – underlying financial position deficit at P8 (£3m variance) Forecast (£4m) Adverse full year **Rational for risk tolerance score:** A likelihood score of 2 would demonstrate that the underlying financial position needs to be strong and financial performance targets will be met as a priority. **Additional comments** Corrective actions have already been identified. The position has been notified to NHS England office and formalised in this month's return.	

Risk PC1: Lack of accurate data on out of hospital mortality may result in areas of high risk not being identified or addressed		**Lead Director/risk owner: Director of Primary Care**	
Strategic Objective - All objectives		**Date of last review**: 29.11.16	
Controls (what mitigating actions are being taken): Community mortality action plan.	**Actions** Analysis of Dr Foster data including review of timeliness Roll out of Gold Standard Framework project	**Owner** D of PC D of PC	**Due date** November 2016 March 2017
Gaps in Controls - Roll out of end of life gold standard framework to be fully implemented.			
Assurances (how do we know if the things we are doing are having an impact?): CCG Quality Group – overview of performance data		**Gaps in assurances** (what additional assurances should we seek?): None	

Risk Rating likelihood 3 impact 4

Current Score:
12
Risk tolerance:
4 x 2 = 8
Source of Risk:
Ability of NLaG to share in-depth mortality data with community



Reasons for current risk score:
Impact (4) for risk of not learning from or incorporating actions to develop care networks.
Likelihood (3) access to Dr Foster data not yet achieved.

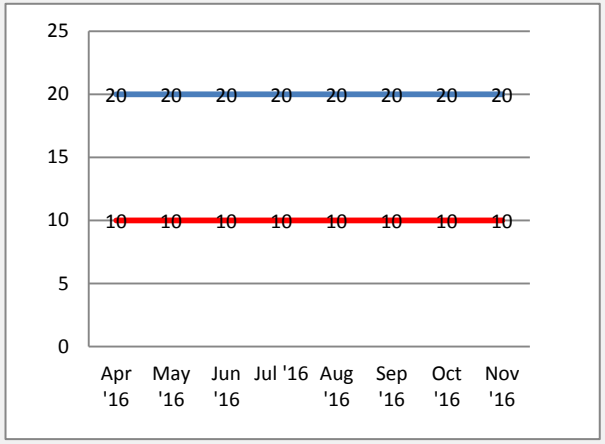
Rational for risk tolerance score:
Likelihood Score of 2 demonstrates information has been accessed with subsequent actions in place

Additional comments
Subject to accessing Dr Foster data for individual practices it is anticipated that the risk score will be reduced and removed from the assurance framework

Risk PC2: Inability to recruit sufficient GPs and nurses could lead to difficulty maintaining current level of service and quality outcomes for patients		**Lead Director/risk owner: Director of Primary Care**	
Strategic Objective: Linked to all strategic objectives.		**Date of last review**: 29.11.16	
Controls (what mitigating actions are being taken): The CCG is participating in the Health Education England (Yorkshire & Humber) Scheme to recruit more GPs and practice nurses	**Actions** Hub and Spoke Model to be included in Primary Care Development Plan – to identify ways of working with practices to increase recruitment and promote sustainability Working with local NHS England to develop the viability of services to existing practice lists (currently 2 practices).	**Owner** D of PC D of PC	**Due date** November 2016 April 2017
Gaps in Controls - None			
Assurances (how do we know if the things we are doing are having an impact?): Each of the following provides a partial assurance/overview of the current position faced by NLCCG:- CQC NHS England Healthwatch NLCCG Joint Commissioning Group		**Gaps in assurances** (what additional assurances should we seek?):	

Risk Rating likelihood 4 impact 5

Current Score:
20
Risk tolerance:
5 x 2 = 10
Source of Risk:
Primary care data



Reasons for current risk score:
Impact – Reduction of services to patients
Likelihood – High retirement rate amongst GPs and nurses and low recruitment to local area

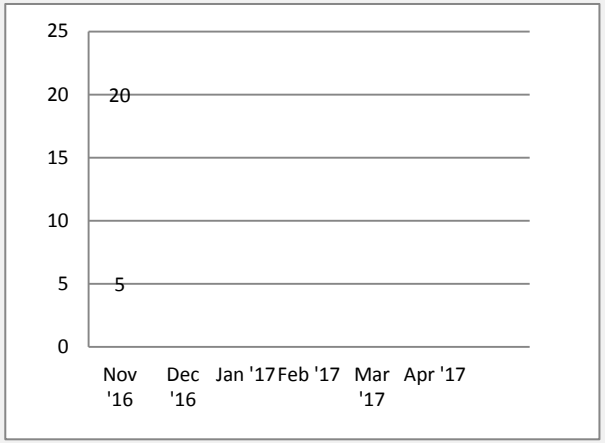
Rational for risk tolerance score:
Likelihood score of 2 would indicate that recruitment situation is positive for nurses and doctors combined possibly with a low turnover rate

Additional comments
Actions to reduce this risk continue to be extremely challenging due to the national context as well as the local position.

Risk PC3: That Medicines Management programme will not deliver planned QIPP savings for 2016/17		**Lead Director/risk owner: Director of Primary Care (DPC)**	
Strategic Objective: A, B, C		**Date of last review**: **29.11.16 (first)**	
Controls (what mitigating actions are being taken):	Actions	Owner	Due date
	Rolling programme of implementation for Medicines Optimisation Strategy	DPC	April 2017
QIPP recovery plan			
	To monitor progress via monthly meetings	DPC	On-going
Actions from Internal Audit review agreed and being monitored	Appointment of new clinical lead	DPC	December 2017
	Improve efficiency of APC	DPC	April 2017
Gaps in Controls To complete recruitment process to Medicines Management Team Lack of Clinical Lead			
Assurances (how do we know if the things we are doing are having an impact?): Reports on QIPP delivery plan. Monthly Budget Meetings		**Gaps in assurances** (what additional assurances should we seek?):	

Risk Rating
Impact 5
Likelihood 4

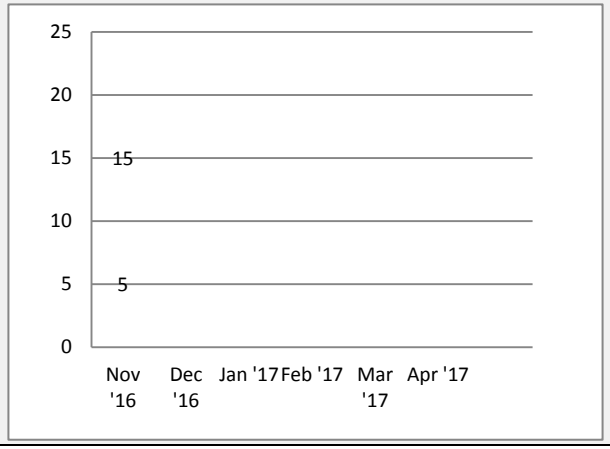
Current Score:
5 x 4 = 20
Risk tolerance:
5 x 1 = 5
Source of Risk:
Ability of NECS to manage performance and willingness of GPs to engage with strategy



Reasons for current risk score:
Significant overspend at this point with lack of traction and performance management from NECS

Rational for risk tolerance score:
It is acknowledged that there will always be some challenge to delivering savings

Additional comments

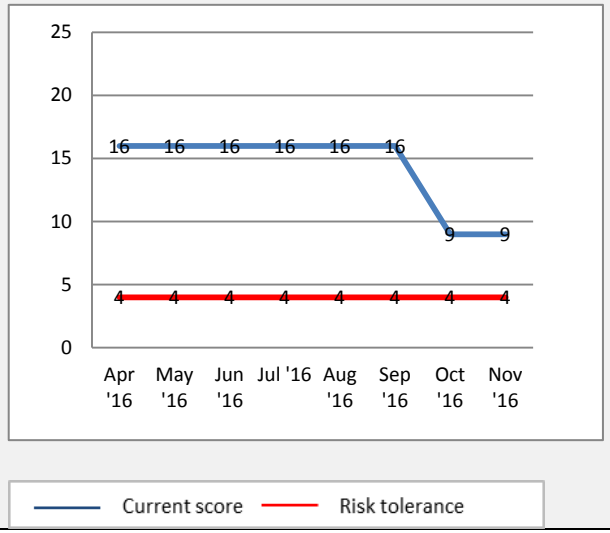
Risk PC 4: If ACP is not effectively established there will be a failure to make quality improvements, maximise financial benefits and move services into the community ultimately leading to a failure in our 'place' response to HLHF.		**Lead Director/risk owner: Director Primary Care (DPC)**	
Strategic Objective: All		**Date of last review**: **29.11.16 (first)**	
Controls (what mitigating actions are being taken): Appointment of a dedicated Models of care Delivery Team Close working between CCG and Strategic Commissioning Group ACP Executive Board	Actions For all ACP members to be in place Engagement work with practices and LMC Review of options to determine legal entity	Owner DPC DPC DPC	Due date February 2017 On-going January 2017
Gaps in Controls Not all Team members yet in post Lack of clarity around desired contracting structure and current gaps and assets	The GP federation does not have full engagement from all practices The ACP is currently a loose structure with no legal entity		
Assurances (how do we know if the things we are doing are having an impact?): Progress report to CCG Executive and Strategic Commissioning Group		**Gaps in assurances** (what additional assurances should we seek?): Implementation Plan currently being drawn up by Programme Manager	
Risk Rating likelihood 3 x impact 5 **Current Score:** 15 **Risk tolerance:** 5 **Source of Risk:** Willingness of independent providers and GPs to engage		**Reasons for current risk score:** Failure to achieve would result in significant impact on CCG performance. Score of 3 reflects significant amount of work which has been undertaken whilst acknowledging progress is still required **Rational for risk tolerance score:** A score of 0 is given as the ACP needs to be effectively established **Additional comments**	

Risk Q4: Risk to CCG regarding delayed delivery of retrospective claims.		**Lead Director/risk owner: DN&Q**	
Strategic Objective: Linked to A,B,C,D		**Date of last review**: 30/11/16	
Controls (what mitigating actions are being taken): Collaborative arrangements with Doncaster CCG. MOU in place with governance arrangements and agreed trajectory. Achievement of trajectory monitored NHSE returns completed monthly	**Actions** 1 Monitor the performance of collaborative PUPOC service 2. Review of data accuracy with Doncaster CCG 3 Anticipate further cohort of PUPOC in 2017	**Owner** Hof N Hof N Hof N	**Due date** On-going October 2016 – completed January 2017
Gaps in Controls **Performance targets yet to be achieved.**			
Assurances (how do we know if the things we are doing are having an impact?): Monthly monitoring of performance data shows progress towards trajectory. Progress is on target for agreed achievement.		**Gaps in assurances** (what additional assurances should we seek?):	

Risk Rating likelihood 3 impact 3
Current Score: 9

Risk tolerance: 4

Source of Risk:
CHC performance data from Doncaster CCG.



Reasons for current risk score:
Impact: Significant financial, in addition to quality and service delivery risks
Likelihood: Significant challenge remains to meet agreed trajectory

Rational for risk tolerance score: Score of 4 with a likelihood of 0 relates to a position when the backlog is down to zero.

Additional comments

Risk Scoring Matrix (NPSA)

Probability (Likelihood) x Severity (Consequences) = Risk

All risks need to be rated on 2 scales, probability and severity using the scales below.

Probability

Risks are first judged on the *probability* of events occurring so that the risk is realised.

Enter a number (1-5) indicating the probability of the risk occurring. Please refer to the definition scale below.

		Broad descriptors of frequency	**Time framed descriptors of frequency**
1	Rare	This will probably never happen/recur	Not expected to occur for years
2	Unlikely	Do not expect it to happen/recur but it is possible it may do so	Expected to occur at least annually
3	Possible	Might happen or recur occasionally	Expected to occur at least monthly
4	Likely	Will probably happen/recur but it is not a persisting issue	Expected to occur at least weekly
5	Almost certain	Will undoubtedly happen/recur, possibly frequently	Expected to occur at least daily

Almost certain	5	10	15	20	25
Likely	4	8	12	16	20
Possible	3	6	9	12	15
Unlikely	2	4	6	8	10
Rare	1	2	3	4	5
Probability / **Severity**	**Negligible**	**Minor**	**Moderate**	**Serious**	**Catastrophic**