Assurance Framework Snapshot December 2018

Ref	Risk Scenarios	Risk Owner	Gross Risk Exposure	Gross Risk Exposure Rating	Net Risk Exposure	Net Risk Exposure Rating	Risk Movement		June 2018 Net Risk	March 2018 Net Risk	December 2017 Net Risk	September 2017 Net Risk	June 2017 Net Risk	March 2017 Net Risk
RS01 GB_16 Linked to CO 2	IF we do not maintain good strategic relationships with providers, practices, local authorities, NHS England, other CCGs and the voluntary sector THEN we may not be able to deliver the necessary transformational charge to meet the aspirations of the Five Year Forward View whilst remaining in financial balance	**Clinical Chief Officer**	12	H	8	H	⇔		8	8	8	8	8	8
RS02 GB_20 Linked to CO 1, 2	IF we do not have the right skills, knowledge and capacity in our leadership, management teams and our commissioning support services THEN we may not be able to manage both our day to day operations and the delivery of our strategic objectives	**Clinical Chief Officer**	16	E	6	M	⇔		6	6	6	8	8	6
RS03 GB_13 Linked to CO 2, 3	IF we do not have a local workforce with the right skills and capacity THEN this may impact on the ability of local service providers to deliver high quality care. Also the necessary level of transformational change to deliver sustainable models of care.	**Director of Strategy and Operations**	8	H	8	H	⇔		8	8	8	8	8	8
RS04 GB_08 GB_11 Linked to CO 1, 2, 3	IF we do not have effective performance and quality governance structures in place THEN we will be unable to assure ourselves of the quality of commissioned services and that any emerging quality issues are identified and appropriately mitigated	**Director of Nursing**	16	E	6	M	⇔		6	6	6	6	6	6
RS05 Linked to CO 1, 2, 3	IF we do not have effective corporate governance, decision making structures, member engagement and patient involvement in place THEN we may not make the most appropriate decisions for our citizens and may be open to legal challenge	**Clinical Chief Officer**	15	E	6	M	⇔		6	6	6	6	6	6
RS06 Linked to CO 2	IF we do not accelerate and embed the adoption of technology and information sharing in clinical and corporate areas THEN we will be unable to transform services and deliver the best possible care for our citizens	**Director of Finance & Performance**	8	H	6	M	⇔		6	6	6	6	6	6
RS07 GB_23 Linked to CO 2	**IF** we do not develop robust care models which inform utilisation and development of the local health and local authority estate **THEN** the CCG may not achieve the expected outcomes for local people. There may also be avoidable financial and service delivery consequences	**Director of Strategy and Operations**	12	H	12	H	⇔		12	12	12	12	12	12
RS08 GB_02 Linked to CO 1, 2, 3	**IF** we do not commission high quality and cost effective models of care, which offer improved value for money transformational plans **THEN** we will be unable to achieve improvements in performance, meet continued demand for healthcare and meet the ongoing financial challenges	**Director of Strategy and Operations**	20	E	12	E	⇔		16	16	16	16	16	16
RS09 GB_03 GB_04 GB_05 GB_10 Linked to CO 1	**IF** we do not have the right information to be assured we are meeting the NHS constitutional standards, statutory standards and other key performance targets **THEN** this will impact on the CCGs ability to execute its responsibilities to commission high quality care and improved outcomes for local people. It will also impact on the functioning of the system and ultimately on outcomes for local people	**Director of Strategy and Operations**	20	E	8	H	⇔		8	8	8	8	12	8
RS10 Linked to CO 1, 2	IF we do not have the right financial, activity and performance information THEN we may not be commissioning value for money services and will be unable to meet our financial challenges	**Director of Finance & Performance**	20	E	12	H	⇔		12	12	12	12	12	15
RS11 Linked to CO 1	**IF** we do not effectively plan for the longer term commissioning of care services which meet the identified health needs of local people **THEN** we will not effectively reduce health gaps and prevent ill health	**Director of Strategy and Operations**	8	H	8	H	⇔		8	8	8	8	8	8
RS12 Linked to CO 1,2	**IF** we do not have the right information about the impact of legislation and regulatory requirements on health and social care **THEN** we will fail to meet these requirements	**Clinical Chief Officer**	9	H	6	M	⇔		6	6	6	6	6	6
RS13 Linked to CO 1,2	**IF** we do not actively manage and stimulate the care market, in particular care home providers and other care providers outside of the NHS **THEN** the social, voluntary and commercial providers may not be able to effectively respond to our commissioning intentions and therefore we may not be able to deliver the transformed services in the way we intend	**Director of Strategy and Operations**	12	H	8	H	⇔		8	8	8	8	8	8
RS14 Linked to CO 1, 2	**IF** the CCG partnership working arrangements fail to identify and uncover any threats to the financial sustainability of our local NHS providers and local authorities, **THEN** we will not be able to commission the right services in the right settings with the right outcomes for our patients, at an affordable price.	**Clinical Chief Officer**	15	E	8	H	⇔		8	8	8	8	8	15
RS15 Linked to CO 1,2	**IF** the CCG does not have appropriate representation on and delegated to ICS groups and committees **THEN** we may not be able to discharge our statutory responsibilities to commission the right services in the right settings with the right outcomes for our patients, at an affordable price.	**Clinical Chief Officer**	15	E	6	M	⇔		6	6	6	12	12	15
RS16 Linked to CO 1	**IF** the CCG does not have sufficient financial resources **THEN** we may not be able to discharge our statutory responsibilities to commission the right services in the right settings with the right outcomes for our patients, at an affordable price.	**Director of Finance & Performance**	16	E	12	H	⇔		12	12	12	12	12	12
RS17 GB_17 **Linked to CO 2**	**IF** we have conflicting Governance processes with the ICS due to the organisations difference in maturity **THEN** we may not be able to deliver the necessary transformational change due to organisational differences and assurances.	**Clinical Chief Officer**	12	H	8	H	⇔		8					

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Compliance Linked ID No	Risk Owner	Principal Risk	**Controls** *(Measures in place to mitigate this risk)*	Gross Likelihood Gross	Consequences	Gross Risk Exposure	**Internal** Assurances on Controls *(Where this risk is monitored via governance reporting mechanisms including STP)*	**External** Assurances on Controls *(Where this risk is monitored via governance reporting mechanisms)*	**Gaps** in Controls / Assurances *(where controls are not fully working or further controls are required and limited assurance has been achieved. To include external controls from NHSE and NHSI)*	Net Likelihood	Net Consequences	Net Risk Exposure	**Actions (SMART)**	**Action Owner and deadline for the action to be completed**	Risk Movement			June 2018 Net Risk	March 2018 Net Risk	December 2017 Net Risk	September 2017 Net Risk	June 2017 Net Risk	March 2017 Net Risk	
RS01 GB_16 **Linked to CO 2**	Clinical Chief Officer	**IF** we do not maintain good strategic relationships with providers, practices, local authorities, NHS England, other CCGs and the voluntary sector **THEN** we may not be able to deliver the necessary transformational charge to meet the aspirations of the Five Year Forward View whilst remaining in financial balance	1. Voluntary Sector strategies with Local Authority 2. Regular "Assembly" meetings with member practices 3. Systems Leaders group 4. Director led meetings with key providers 5. CCG Communication Strategy 6. Engagement processes for developing CCG strategies 7. Better Care Fund oversight groups 8. ICS meetings	3	4	12	1. CCG Governing Bodies and the Executive Management Team (EMT) 2. Business cases and GB papers should describe engagement with stakeholders and result of it 3. Refreshed and enhance Systems Leaders group, with senior representation from all key partners	1. NHSE CCG Assurance Framework monitoring includes leadership 2. Scrutiny from Health & Wellbeing Boards 3. Annual 360 degree review of CCG by key stakeholders	1. Lack of consistent engagement with voluntary sector 2. GB papers and Business Cases do not always fully describe engagement 3. ICS engagement with public weak to-date	2	4	8	1. More systematic engagement with voluntary sector 2. GB papers need to include Business Cases describing engagement 3. Development of Clinical Strategy will help with member engagement	01/03/2019 1.Locality leads Health and Wellbeing Boards 2.Director of Strategy and Operations. 3. Clinical Chief Officer March 2019	⇔			8	8	8	8	8	8	
RS02 GB_20 **Linked to CO 1, 2**	Clinical Chief Officer	**IF** we do not have the right skills, knowledge and capacity in our leadership, management teams and our commissioning support services **THEN** we may not be able to manage both our day to day operations and the delivery of our strategic objectives	1. Review of federated and CCG specific team capacity / roles 2. Individual staff personal development plans (PDPs) 3. Statutory and mandatory training, professional and technical training 4. Organisational Development plans and reports on progress 5. Training statistics (incl statutory and mandatory training) 6. Agreed SLA with CSU for core and additional services. 7. Regular review of CSU performance 8. Succession plans in place	4	4	16	1. CCG Governing Bodies. 2. CCG Committee Meetings 3. CCG Executive Team 4. CCG/CSU monthly performance reviews with CSU at joint director level	1. NHS England approval of CSU competence (accreditation on Lead Provider Framework) 2. NHSE CCG Assurance Framework - domain on leadership and quarterly assurance meeting 3. Internal Audit reports	1. Review of capacity and roles now completed however overreliance on interim staff until vacancies recruited 2. Some CSU service line specifications need to be redesigned to fit the CCG requirements 3.-Organisational Development Strategy in progress 4. potential gap as Clinical Chief Officer part-time 5.Staff undertaking East Berkshire work as well as ICS	2	4	6	1. Recruit to vacant posts in new structure 2. Director of Nursing to oversee and implement OD program of work 3. Some CSU service line specifications need to be redesigned to fit the CCG requirements 4. Work with Consult HR on the wider talent management agenda. 5. CSU contract extended 6. Review leadership structure in the light of new commissioning arrangements in the ICS	01/03/2019 1. All senior staff 2. Director of Nursing 3. Deputy Director of Finance 4. Director of Nursing 5 Deputy Director of Finance 6. Clinical Chief Officer	⇔			6	6	6	8	8	6	
RS03 GB_13 **Linked to CO 2, 3**	Director of Strategy and Operations	IF we do not have a local workforce with the right skills and capacity THEN this may impact on the ability of local service providers to deliver high quality care. Also the necessary level of transformational change to deliver sustainable models of care.	1. Provider Contract specifications 2. Working with Health Education England and other relevant bodies on forward plans for workforce capacity and training 3. Contract review meetings (including review of workforce date) 4. Joint governance and contractual arrangements 5. Regular, effective and meaningful engagement at a strategic level across the system 6. Living wage from minimum wage 7. Monitoring and investigation of serious incidents in provider services will flag staffing related incidents	2	4	8	1.Quality Committee receives contract performance reports from contract review meetings 2. QIPP and Transformation plans include risks and issues logs which cover workforce issues 3. Local Workforce Advisory Board now in place which oversees workforce across all the main ICS workstreams 4. Workforce is a key area of the GPFYFV and the transformation programme for Primary Care. CEPN role in place 5. Reports to ICS and local Health and Social Care groups include workforce issues where these are a challenge to delivery of services. 6.ICS workforce strategy in place and implementation being led by ICS workforce strategy group	1. CQC reports 2. NHSE CCG Assurance Framework - domain on leadership and quarterly assurance meetings 3. ICS workforce plans - including PC transformation 4. Service risk registers 5. Provider workforce plans in place	1. lack of alignment of workforce plans across multiple transformation programmes at CCG and ICS level	2	4	8			⇔			8	8	8	8	8	8	
RS04 GB_08 GB_11 Linked to CO 1, 2, 3	Director of Nursing	**IF** we do not have effective performance and quality governance structures in place **THEN** we will be unable to assure ourselves of the quality of commissioned services and that any emerging quality issues are identified and appropriately mitigated	1. CQC Regulations and main providers compliant with CQC 2. CQC Action Plans monitored by CCG and CQC 3. National and Local Policy/ regulatory standards. 4. Contracts with providers includes Quality Schedule, national and constitutional targets 5. Contract monitoring of schedules 6. Serious Incidents reports 7. Serious Incident Review Group bi-monthly 8. Infection Control reports. 9. Safeguarding procedures. 10. NICE/Quality Standards. 11. Patient Surveys.	4	4	16	1. Quality meetings with Provider. 2. Site visits. 3. Quality Committee receives performance information including Serious Incident reports and Serious Incident Review Group bi-monthly 4. Health Strategic Safeguarding meeting 5. Safeguarding reports and dashboard. 6. Patient Experience /Complaints reports 7. CCG quality dashboards. 8. Bi-monthly quality reports and minutes from CQRM 9. Monthly Quality and performance presentation to Governing Body	1. CQC inspections of providers and provider action plans. 2. NHSE CCG Assurance Framework monitors delivery against financial and activity plans 3. NHSE CCG Assurance Framework - domain on leadership and quarterly assurance meetings 4. Themes from national Serious Case Reviews 5. Clinical Audit reports 6. Internal audit review of governance committees 7. Action Plans from contract performance notices and observational visits 8. ICS Quality and Performance Committee	1. Lack of peer review of quality monitoring 2.The CCG is an Associate commissioner with some of the contracts hence there is limited influence and controls in some contract areas	2	3	6	1. Quality and performance peer review (from Jan 2016) peer review established and meeting every other month 2. Quality team to review all the quality information sent to them and attend the high risk CQRM.		⇔			6	6	6	6	6	6	
RS05 Linked to CO 1, 2, 3	Clinical Chief Officer	**IF** we do not have effective corporate governance, decision making structures, member engagement and patient involvement in place **THEN** we may not make the most appropriate decisions for our citizens and may be open to legal challenge	1. CCG Constitutions and joint terms of reference 2. 5 Year Strategy and CCG Operating Plans 3. Annual Governance statement 4. Refreshed Corporate Governance team 5. CCG Policies and Procedures	3	5	15	1. Executive and Governing Body reporting 2. Patient Survey results 3. Assurance Framework 4. Annual 360 degree survey of key CCG stakeholders. 5. CCGs have achieved level 2 against the Information Governance toolkit. 6. Milestone tracker	1. External Audit reports 2. Internal Audit reports 3. NHSE CCG Assurance Framework monitors delivery against Finance, Planning and Well-lied Organisation.	1. Collaborative commission around new Frimley footprint needs to be embedded 2. CCG constitutions and policies need updating	2	3	6	1. Senior level engagement at ICS planning events. 2. Refreshing the CCG constitutional frameworks 3. Policy development and refreshing CCG policy base	March 2019 Director of Nursing	⇔			6	6	6	6	6	6	
RS06 Linked to CO 2	Director of Finance & Performance	**IF** we do not accelerate and embed the adoption of technology and information sharing in clinical and corporate areas **THEN** we will be unable to transform services and deliver the best possible care for our citizens	1. Jointly agreed IM&T Strategy 2. Executive Lead Officer/ CCG Lead 3. Digital Roadmaps 4. Senior Responsible Officer (SRO) for Connected Care (Interoperability) Project, and weekly reporting on project implementation plan 5. DXS implementation plan 6. CSU Contract for IG and ICT 7. IG Toolkit Version 13 8. IM&T Committee 9. Sustainability and Transformation Plan (ICS) has IM&T as an enabling workstream	2	4	8	1. Joint Connected Care (Interoperability) Project Board 2. DXS Project Board 3. Exec Team and Senior managers oversee delivery of IT strategy 4. IM&T Committee reviewing issues as arise 5. System Leaders Group oversight of ICS 6. Frimley Local Digital Roadmap Board	1. Internal Audit Review 2. NHS Digital / England oversight of Connected Care Project and have regional / national perspective on matters of IMT 3. NHSE CCG Assurance Framework monitors delivery against activity plans including Digital Roadmaps 4. NHSE CCG Assurance Framework - domain on leadership and quarterly assurance meetings 5. NHS England review and approval of Digital Roadmaps 6. CCG part of Thames Valley Surrey, LHCRE(Local Health Care Record Exemplar) programme with National oversight from NHSE/ID.	1. Representatives from partner organisations on Connected Care Board may not have sufficient authority to commit their organisations, or may have differing priorities 2. Chief Clinical Information Officer(CCIO) for the CCGs resigned	2	3	6	1. System Leaders regularly reviewing digital agenda and point of escalation for issues 2. Consider CCIO role across ICS footprint. CCIO's across Frimley patch working more closely in support of ICS wide digital projects mitigating lack of local East Berks CCIO.		⇔			6	6	6	6	6	6	

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RS07 GB_23 **Linked to CO 2**	Director of Strategy and Operations	**IF** we do not develop robust care models which inform utilisation and development of the local health and local authority estate **THEN** the CCG may not achieve the expected outcomes for local people. There may also be avoidable financial and service delivery consequences	1.NHSE approved ICS Strategic Estates Plan and "Statements of Need" 2. Dedicated Programme lead in place 6. Local project support in place 7. CCG Clinical strategy framework agreed 3. CCG Operating Plan and Primary Care Strategy and Infrastructure plan approved to inform the type of estate needed 4.NHSI/E phase 2 funding agreed to support capital investment in estates development to support integrated care 5. Primary Care Estates technology Transformation Fund bidding process 6. Sustainability and Transformation Plan (ICS) has estates as an enabling work stream and CFO SRO 7. Wider engagement with Local Authorities via One Public Estate initiative and East Berkshire Systems Leaders 8. Strategic Estates Advisor from NHSI identified to work with the system	3	4	12	1. Executive Team oversight 2. East Berkshire Transformation programme group 3. East Berkshire System Leaders Group oversight of key estates opportunities 4. ICS Estates strategy group now in place	1. Internal audit review 2. NHS England/Improvement review of Estate Strategy 3. ICS Leadership Board review of Estates programme 4. NHSI review of individual schemes and business cases 5. NHSE CCG Assurance Framework monitors delivery against financial and activity plans 6. NHSE CCG Assurance Framework - domain on leadership and quarterly assurance meetings	1. Clinical transformation to be articulated at place and translated into an affordable set of estates requirements within the timescales required for submission of OBC to NHSI 2. Plans require Public/Stakeholder engagement and co-design of plans critical to success of schemes 3. Some plans may be subject to submission and approval of formal planning applications 4. Business cases require approval by NHSE/I 5.the affordability of revenue implications 6. Delivery of plans may be subject to formal public consultation 7. approval of plans may be linked to the release of vacant NHSPS premises or land	3	4	12	Approval of business cases by GB and ICS leadership	FSB	⇔			12	12	12	12	12	12	
RS08 GB_02 **Linked to CO 1, 2, 3**	Director of Strategy and Operations	**IF** we do not commission high quality and cost effective models of care, which offer improved value for money transformational plans **THEN** we will be unable to achieve improvements in performance, meet continued demand for healthcare and meet the ongoing financial challenges	1. CCG has a series of transformation programmes, which also align with the ICS priorities and programme of work. 2. The CCG produces annual commissioning intentions and a response to the Operating plan for the NHS also on an annual basis which sets out the priorities and deliverables for the coming year. 3. All QIPP and investment programs have detailed plans which have clinical leadership and which have been developed in partnership with local providers 4. Processes in place to monitor commissioned care delivery from both and financial and non financial perspective - quality is monitored through the Quality and Constitutional standards committee 5. The locality Performance Review Groups review performance monthly 6. Budgetary control system and QIPP Tracker	4	5	20	1. transformation programmes are developed through clinical engagement, and in line with local and system priorities which are informed by business intelligence, Right Care data, quality performance etc., 2.Quality and Constitutional standards committee and QIPP and finance committee receive regular reports on provider performance. 3. Business Planning and Clinical Governance considers business cases for all proposals for all local newly commissioned services and each business case includes requirement for quality and financial sign off in advance of submission 4. Senior Clinical and Managerial Leadership in place for every scheme 5. Consistent and robust business case documentation and prioritisation framework in place 6. All business cases approved via BP&CC, or other committees under SoD. 7. CCG Performance review groups monitor impact monthly - see minutes 8. Monthly reports to Q&F - see minutes 9. dedicated financial support in place to develop new QIPPs	1. Internal Audit reports. 2. External Audit reports 3. NHSE Operating Plan sign off process 4. CCG publishes its commissioning intentions on its website annually 5. NHS England CCG assurance process will monitor quality outcomes and financial performance	1. Business intelligence data is not always timely	3	4	12			⇔			16	16	16	16	16	12	
RS09 GB_03 GB_04 GB_05 GB_10 **Linked to CO 1**	Director of Strategy and Operations	**IF** we do not have the right information to be assured we are meeting the NHS constitutional standards, statutory standards and other key performance targets **THEN** this will impact on the CCGs ability to execute its responsibilities to commission high quality care and improved outcomes for local people. It will also impact on the functioning of the system and ultimately on outcomes for local people	1. CCG contract with providers includes all NHS constitutional targets including cancer, 18 week target, A&E 4 hour wait, CAMHS 2. 18 week Dashboard 3. 18 week recovery plan 4. Situation reports with daily conference calls 5. Systems Resilience Plan 6. Non elective QIPP targets 7. Cancer improvement plan 8. Cancer pathway 9. Performance improvement notices and remedial plans in place where required	4	5	20	1. Quality Committee receives reports from the Clinical Quality Review Group and monitors provider performance including RTT, Cancer standards, MH access standards etc. 3. Performance Review Group monitors data at a practice level and actions agreed for outlier practices 4. Regular reports and monthly monitoring performance reports at GB from Head of Performance 5. Integrated Contract Performance Review meeting in place which monitors performance with FHFT	1. NHS England review of CCG and provider performance	1. Performance information is historic rather than in real-time. 2. Delays in data production from CSU can be challenging	2	4	8	1. Monitor CSU performance through the SLA meetings		⇔			8	8	8	8	8	8	
RS10 Linked to CO 1, 2	Director of Finance & Performance	**IF** we do not have the right financial, activity and performance information **THEN** we may not be commissioning value for money services and will be unable to meet our financial challenges	1. Annual CCG Financial Plans 2. Medium term STP financial and activity plan 3. Monthly financial and activity reporting 4. Planning assumptions in line with best practice recommended by NHS England. 5. Plans scrutinised by Governing Body. 6. Detailed monthly financial reports to Governing Body. 7. CCG has Standing Orders, Prime Financial Policies and other detailed financial policies and procedures 8. Audited accounts. 9. Contractual monitoring and review processes 10. Specification of CSU services	4	5	20	1. GB and Finance & QIPP Committee receives monthly financial and activity reporting 2. Stress testing of financial plan in different scenarios 3. Review of business cases 4. Three CCG QIPP and Performance Groups to maintain individual CCG focus 5. Regular CSU meetings 6. ICS Finance Reference Group 7. Connected Care and ICS Analytics Reference Group	1. NHSE CCG Assurance Framework 2017/18 2. NHS England review of financial plan and monthly review of in year financial position. 3. Reviews on financial systems/processes by internal and external audit. 4. External audit VFM reviews. 5. Monitoring from NHSE and NHSI of STP plans	1. Limited information from BHFT due to block contract. 2.CSU inconsistent support e.g. PPM 3. Inconsistencies in the completeness of the information provided means the CCGs have limited assurance 4. Commissioning information records price of activity not cost, therefore may be misleading 5. Lack of 'whole pathway' costing	3	4	12	1. CSU specification refreshed and new model of service proposed by CSU to standardise across Frimley footprint - both discussions focussing on partnership working across the Frimley footprint and developing system dashboard ongoing. 2 BHFT and FHFT investment in better costing information and tools. FHFT and BHFT are both in the process of implementing, costing information to be available in 2018. 3. National ACS support team looking at support to system costing. 4. The Frimley System is working to a shared system control total. 5. the Frimley system is developing a process for addressing risks and mitigations across the system."		⇔			12	12	12	12	12	15	

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RS11 Linked to CO 1	Director of Strategy and Operations	**IF** we do not effectively plan for the longer term commissioning of care services which meet the identified health needs of local people **THEN** we will not effectively reduce health gaps and prevent ill health	1. Local Health and Wellbeing strategies 2. PH profiles available for all localities 3. National policy delivery e.g. 10 year plan 4. ICS Strategic plan	2	4	8	1. Public Health directly involved in the development of the annual Operating Plans and in the work streams of the ICS 2.PH profiles and population inequalities data used to inform planning along with Right Care data 3. CCGs Plans reflect local Health and Wellbeing strategies 4. Business cases include Equality impact assessments	1. NHSE CCG Assurance Framework 2. NHS England review of Operating and system plans 3. HWB approval of plans	Long term contracts not in place for all providers to enable certainty of provision to meet strategic aims for reducing health inequalities	2	4	8			⇔			8	8	8	8	8	8	
RS12 Linked to CO 1,2	Clinical Chief Officer	**IF** we do not have the right information about the impact of legislation and regulatory requirements on health and social care **THEN** we will fail to meet these requirements	1. Annual Governance Statement 2. Corporate Risk Register 3. Specification of CSU services 4. Appropriate qualified CCG staff	3	3	9	1. Regular contracts and CSU meetings 2. CCG management review of transferred functions and options to adapt structure to accommodate non-CSU provided functions	1. Internal Audit 2. External Audit 3. NHS England	1. CSU specification refresh 2. Single points of failure (CCG staff)	2	3	6	1. CSU specification refresh	01/03/2019 Deputy Director of Finance.	⇔			6	6	6	6	6	6	
RS13 Linked to CO 1,2	Director of Strategy and Operations	**IF** we do not actively manage and stimulate the care market, in particular care home providers and other care providers outside of the NHS **THEN** the social, voluntary and commercial providers may not be able to effectively respond to our commissioning intentions and therefore we may not be able to deliver the transformed services in the way we intend	1. ICS lead Care and Support Market work stream leading on this for the system - including the CCG 2. Care Homes Quality group in place across East Berkshire - dedicated Quality lead employed jointly by CCG and LAs	3	4	12	1. Work streams of the ICS directly related to market management of social care and voluntary sector providers - produces regular update to ICS Programme Delivery Board 2. Commissioning intentions are shared with providers annually 3. active engagement with providers and monitoring of quality through the Care Homes Quality group for East Berkshire	NHSE review of ICS Operating plan	1. Signed of care and support market management plan	2	4	8		ICS Care Support Market workstream	⇔			8	8	8	8	8	8	
RS14 Linked to CO 1, 2	Clinical Chief Officer	**IF** the CCG partnership working arrangements fail to identify and uncover any threats to the financial sustainability of our local NHS providers and local authorities, **THEN** we will not be able to commission the right services in the right settings with the right outcomes for our patients, at an affordable price.	1. Development of System Sustainability and Transformation Plans 2. 2017/18 provider contracts, with robust contracting arrangements in place with providers including all NHS constitutional targets for cancer, 18 week target, A&E 4 hour wait 3. Continuing Healthcare/Mental Health Individual Packages of Care; regular monitoring of forecast spend against budget for managing position intervention 4. Robust performance management arrangements and relationships with providers well established via monthly contract review meetings	3	5	15	1. CCG Governing Bodies and Committees 2. Performance and QIPP Review Group monitors actions agreed for outlier practices 3. Regular exception reports and monthly monitoring performance reports 4. Stress testing of financial plan in different scenarios commissioned as part of the ICS development 5. ICS-wide Finance Reference Group reviewing system financial position	1. Provider data and annual reports 2. External Service reviews to determine an appropriate way forward. 3. NHS England review of financial plan and monthly review of in year financial position. 4. NHSE/I assessment / accreditation process for becoming an Accountable Care System	1.Only partial knowledge of financial position of provider organisations' financial position	2	4	8	1. Continue to develop ICS-wide finance model and reporting. 2. CHC Oversight group established 3. A system finance report is produced that is reviewed at ICS Reference Group.	December 2018 Director of Finance	⇔			8	8	8	8	8	15	
RS15 Linked to CO 1,2	Clinical Chief Officer	**IF** the CCG does not have appropriate representation on and delegated to ICS groups and committees **THEN** we may not be able to discharge our statutory responsibilities to commission the right services in the right settings with the right outcomes for our patients, at an affordable price.	1. ICS-wide MOU outlining key features of interim governance arrangements in 2017/18 2. MOU between ICS with NHSE/I which has particular focus on meeting constitutional standards 3. Robust Governing Body challenge	3	5	15	1. CCG Governing Bodies and Committees review of governance 2. Strong CCG representation on all ICS sub groups 3. ICS Programme Board structure established		1. ICS groups in early stage of development and differing levels of effectiveness Continuous assessment of which staff members need to be involved in the ICS e.g. Lay members.	2	3	6	1. Continue to develop ICS wide governance arrangement 2. ICS Programme Board now functional 3. Consider delegation of East Berkshire functions in the light of the ICS.	March 2019 Clinical Chief Officer	⇔			6	6	6	12	12	15	
RS16 Linked to CO 1	Director of Finance & Performance	**IF** the CCG does not have sufficient financial resources **THEN** we may not be able to discharge our statutory responsibilities to commission the right services in the right settings with the right outcomes for our patients, at an affordable price.	1. Annual CCG Financial Plans 2. Medium term STP financial and activity plan 3. Flexibility with individual organisational control totals through operation of shared system control total for ACS 4. Monthly financial and activity reporting 5. Planning assumptions in line with best practice recommended by NHS England. 6. Plans scrutinised by Governing Body. 7. Detailed monthly financial reports to Governing Body. 8. Contractual monitoring and review processes 9. Process for planning achievable QIPP schemes and transformation plans in line with commissioning intentions 10. All QIPP and investment programs have detailed plans, which where appropriate have been agreed with providers 11.. Robust processes in place to ensure delivery of the financial outturn including the QIPP Plan.	4	4	16	1. GB and Finance & QIPP Committee receives monthly financial and activity reporting 2. Stress testing of financial plan in different scenarios 3. STP Finance Reference Group 4. Forward plan of QIPP schemes developed with clinical involvement. 5. Business case development and prioritisation framework in place 6. All business cases approved via BP&CC Committee.		1. Overall level of funding resources set by national allocation process	3	4	12	1. Carry out a Balance Sheet Review for any surplus accruals (ongoing). 2. Review areas of overspend and identify mitigating actions that can be taken (monthly review). 3. Close down any other risks where possible as we approach the yearend 18/19 3. Working with Providers Trusts and other CCGs across the Frimley Health STP to ensure that the system control total is met in 18/19 and working together to produce a joint plan for 19/20.		⇔			12	12	12	12	12	12	

Risk Rating Matrix

Net Impact	5 Frequent	4 Likely	3 Possible	2 Occasional	1 Rare
5	25	20	15	10	5
4	20	16	12	8	4
3	15	12	9	6	3
2	10	8	6	4	2
1	5	4	3	2	1

Net Likelihood

Key Risk Exposure	
	Extreme
	High
	Medium
	Low

CCG Corporate Objectives

1. We will commission services that improve the outcome and experience of all our residents by consistenly delivering the NHS Constitutional Standards.
2. We will play a proactive role in the development and delivery of an innovative and united Sustainability and Transformation Plan
3. We will ensure that Clinical Leadership and patient engagement is at the heart of everything we do and develop a culture that brings to life 'thinking locally, working together'.