SURREY DOWNS CCG - GOVERNING BODY ASSURANCE FRAMEWORK 2017/18

Principal Objective	Lead Exec	Head of Service	Risks to delivery of this objective	Source of risk (where does this come from)	Potential effect of the risk (what might happen)	Assurance (What do we know)	Gaps in assurance (What don't we know)	Controls (what can we do)	Gaps in Controls (what can we not do)	Pre-mitigation likelihood Score	Pre-mitigation impact Score	Net initial Score	Date of latest scoring	Comments on Mitigations	Revised Likelihood Score	Revised Impact Score	Revised Net Score	Risk Appetite range for this category of risk	T Value (Treat, Tolerate, Terminate or Transfer)
P1) Deliver the Financial Recovery Plan and CCG control total, based largely on a successful transformational QIPP programme	Dan Brown	Julian Wilmshurst-Smith	P1(a): Failure to achieve at least 75% of QIPP target	Scale and complexity of QIPP programme	QIPP shortfall would add pressure to find non-recurrent savings in year and add to subsequent years QIPP targets	PMO programme is fully assured - tracked levels of delivery are reliable. Total QIPP is capped so target should not shift.	Viability of specific schemes may be unclear until fully scoped.	Manage projects closely through overall PMO approach and individual programme boards.	Limited influence over. e.g. behaviour in other organisations. Schemes may deliver less than planned following mobilisation.	4	5	20	23/01/2018	Current QIPP achievement forecast being reviewed	4	5	20	High 15-25	Treat
P1) Deliver the Financial Recovery Plan and CCG control total, based largely on a successful transformational QIPP programme	Dan Brown	Julian Wilmshurst-Smith	P1(b) Failure to control contracts with major suppliers	Historical volatility of contracts, particularly acute and non-local contracts	Actual cost pressure generating requirements for additional Non Recurrent Savings and potentially further QIPP schemes	Activity levels from suppliers via Secondary Uses Service and Contract Management System	There are delays in data which means the CCG rarely has real time information.	Strict control over contracts particularly high risk / high value contracts	Provider behaviour ultimately lies outside of CCG control.	4	5	20	23/01/2018	Contracts for 2017-18 have been arranged to reduce risk. However there remains a significant gap between budgeted contracts, QIPP forecast and CCG allocations	4	4	16	Moderate 8-12	Treat
P1) Deliver the Financial Recovery Plan and CCG control total, based largely on a successful transformational QIPP programme	Dan Brown	Carole Melody	P1(c) Unplanned adjustments to central allocations or additional commitments	Historical examples of central changes that cannot be planned for and additional unplanned expenditure (e.g. over-performance on PbR contracts, further unknown contractual pressures)	Actual cost pressure generating requirements for additional Non Recurrent Savings and potentially further QIPP schemes which may not be available or able to generate mitigations in time	Current planning cycle sets out broad scope of allocations. Larger contracts have been commissioned as blocks rather than PbR which removes some of the risk	Unplanned changes to allocations e.g. for emergencies, changes in policy and demand surges to our PbR contracts leading to over-performance issues that need to be funded	Minimal control. Can advocate to minimise changes to allocations. Regarding over-performance would need to either reduce demand or slow throughput - extremely complex and would probably not work in the way required and it would probably cause pressures elsewhere in the system. Also time sensitive. Possibility of negotiating year end deals with over-performing Trusts.	No control over central policy.	3	4	12	23/01/2018	Minimal scope to mitigate central actions.	3	4	12	Moderate 8-12	Tolerate
P2) Take responsibility, with other partners in the footprint, for developing the Surrey Heartlands STP within the framework of locally devolved responsibilities; and ensure that this contributes significantly to the creation of a sustainable health economy with improved outcomes and quality	Donna Derby	Lorna Hart	P2(a) Failure to agree collaborative arrangements with key partner organisations	Complexity of STP arrangements - large number of commissioner and provider organisations working together	STP effectiveness will be severely limited	Memorandum of Understanding in place for Devolution and STP plan submitted and approved in Oct 2016. Broad system wide support for STP in place.	Devolution and STP process still not completely clear and may be subject to change	Continue to develop collaborative arrangements at both devolution and STP levels. Continue to explore risks and benefits of collaboration internally. Devolution in shadow year and STP framework now agreed with centre	No framework in place for mediation or compliance	3	4	12	23/01/2018	Collaborative arrangements under discussion - MOU and terms of reference for joint committee drafted. Work will continue to operationalise arrangements and move through a successful shadow year. Review of S75 agreement taking place	3	4	12	Low 4-6	Treat
P2) Take responsibility, with other partners in the footprint, for developing the Surrey Heartlands STP within the framework of locally devolved responsibilities; and ensure that this contributes significantly to the creation of a sustainable health economy with improved outcomes and quality	Donna Derby	Lorna Hart	P2(b) Failure to engage with / make the case for change to the public on required transformation	Known issues with making the clinical case for change where service delivery is complex and public perceptions associate change with service reduction	Transformational change will be delayed or even abandoned	CCG's have local examples of best practice on engagement and good relationships	None Identified	Work proactively with stakeholders and the media. Ensure that any consultation and decision making processes (particularly around governance arrangements) are legally compliant	Controls over media and public reaction are inherently limited	3	4	12	23/01/2018	For future consideration - no current plans for engagement. Reconsider when STP plans are clearer and actual service changes proposed.	3	4	12	Moderate 8-12	Tolerate
P2) Take responsibility, with other partners in the footprint, for developing the Surrey Heartlands STP within the framework of locally devolved responsibilities; and ensure that this contributes significantly to the creation of a sustainable health economy with improved outcomes and quality	Russell Hills	Lorna Hart	P2(c) Workforce supply issues across the STP cannot be resolved to enable delivery of transformed models of care.	Historical difficulties with recruitment and retention, particularly those sectors of the STP footprint that border London	STP plans will be delayed and there will be an impact on patient care and financial sustainability	Some workforce data available locally and at STP level along with national training numbers	Some gaps in workforce data and some areas difficult to predeict e.g. individual choice of retirement	Some potential for local training, development and incentivisation	Control over central training commissioning is limited. Independent providers are not required to collaborate on workforce strategy.	3	4	12	23/01/2018	For future consideration when STP plans are clearer and actual service change impact on workforce understood.	3	4	12	Moderate 8-12	Tolerate
P2) Take responsibility, with other partners in the footprint, for developing the Surrey Heartlands STP within the framework of locally devolved responsibilities; and ensure that this contributes significantly to the creation of a sustainable health economy with improved outcomes and quality	Dan Brown	Julian Wilmshurst-Smith	P2(d) The STP cannot identify or attract sufficient investment to pump prime transformational change, particularly in the areas of estates, digital infrastructure and skills.	Shortages of national and local investment funds	STP plans will be delayed and there will be an impact on patient care and financial sustainability	Broad understanding of capital requirements to support changes	The CCG lacks assurance about the level and duration of national capital funding	Work with partners and with NHSE to influence allocation process	No control over final decision making at national level	4	4	16	23/01/2018	Discussions taking place with centre on capital allocations to underpin transformational change.	4	4	16	Moderate 8-12	Treat
P3) With partner CCGs, develop the CCG's capacity for the commissioning and delivery of primary care in 2017-18, ensuring that this is consistent with broader commissioning development in areas such as integration.	Donna Derby	Shelley Eugene	P3(a) Lack of investment to make primary care / GP forward view transformation a reality, including delivering the out of hospital agenda and hub capacity	Shortages of national and local investment funds	General practice cannot participate in the CCG primary care strategy and associated workstreams	CCG has good baseline data on primary care estate and IT budgets	Level of funding in any gven planning year	Work with partners and with NHSE to influence investment sums released frm centre.No control over future supply of trained GPs	CCG deos not have delegated commissioning authority. Cannot control the outcome of practice voting on the subject of delegated commissioning that would give it control over local primary care budgets	3	4	12	23/01/2018	Joint work taking place with Guildford and Waverley and NW Surrey CCGs on delivering 5YFV - plans submitted to NHSE	2	4	8	Low 4-6	Treat
P3) With partner CCGs, develop the CCG's capacity for the commissioning and delivery of primary care in 2017-18, ensuring that this is consistent with broader commissioning development in areas such as integration.	Donna Derby	Shelley Eugene	P3(b) Local improvements in primary care access, particularly extended hours, cannot be delivered	Shortages of national and local investment funds; lack of strategic fit with other initiatives	Patients will lack access to a full range of primary care services	CCG has accurate data on local practice access and some feedback on patients experience of accessing appointments	Data on access experience could be improved e.g. waiting times for appointments	The CCG can work with localities and networks to encourage best practice and use of resources e.g. sharing administrative capacity	CCG deos not have delegated commissioning authority that would give it control over local primary care budgets	3	4	12	23/01/2018	Joint work taking place with Guildford and Waverley and NW Surrey CCGs on delivering 5YFV - plans submitted to NHSE. Application of funds at Surrey Downs level agreed with localities.	3	4	12	Low 4-6	Treat
P3) With partner CCGs, develop the CCG's capacity for the commissioning and delivery of primary care in 2017-18, ensuring that this is consistent with broader commissioning development in areas such as integration.	Donna Derby	Shelley Eugene	P3(c) Primary care capacity does not improve due to a lack of primary care workforce planning, skill mix and education	Mismatch between supply of primary care staff particularly GPs and difficulties with existing staff being able to undertake training	Patients will lack access to a full range of primary care services	Some workforce data available on primary care e.g. numbers and age profiles of GPs	Data on workforce could be improved e.g. GP retierment ages	The CCG can work with localities and netowrks to encourage best practice and use of resources e.g. sharing administrative capacity	No control over future supply of trained GPs	3	4	12	23/01/2018	STP wide and national work taking place on ensuring supply of GPs and other skills neeeded in primary care	3	4	12	Low 4-6	Treat
P3) With partner CCGs, develop the CCG's capacity for the commissioning and delivery of primary care in 2017-18, ensuring that this is consistent with broader commissioning development in areas such as integration.	Donna Derby	Shelley Eugene	P3(d) Wider strategic context and general pressures in primary care mean that local practices cannot easily engage	Increasing demand on primary care and difficulties with maintaining supply of GPs to local practices	General practice cannot participate in the CCG's primary care strategy and associated workstreams	Current levels of engagement are good e.g. attenfdance at planned events	Demand can vary unexpectedly and limit capacity	The CCG can work with localities and netowrks to encourage engagement at a CCG wide and locality level	CCG deos not have delegated commissioning authority	3	4	12	23/01/2018	Clinical leadership being developed - clinical cabinet and localities act as focal point for engaging practices	3	4	12	Moderate 8-12	Tolerate
P4) Ensure that the CCG's Organisational Development programmes support localities, clinical leaders, staff and the Governing Body to work locally and across the STP on the successful delivery of both strategic objectives and Business As Usual.	Donna Derby	Becky Brewer	P4(a) Staff turnover and continued use of interims reduces the effectiveness of development programmes	Historical issues with recruitment and retention	Cohesiveness of senior management as a whole is reduced	CCG has accurate workforce data	No known gaps in assurance	EMT meets weekly and can prioritse actions that address workforce issues quickly; positive staff engagement means retention strategies more likely to succeed	Interim workforce market supply is not within CCG control	2	4	8	23/01/2018	At the moment turnover is at acceptable levels however there remain key gaps and a period of destabilisation as the three CCGs determine how they wish to work together. Work taking place looking at locality organisational development	3	4	12	Low 4-6	Treat
P4) Ensure that the CCG's Organisational Development programmes support localities, clinical leaders, staff and the Governing Body to work locally and across the STP on the successful delivery of both strategic objectives and Business As Usual.	Russell Hills	Becky Brewer	P4(b) The effectiveness of clinical and locality leadership is reduced due to the demands of Business As Usual.	Wider system demand inhibiting clinical staff from moving in to leadership roles	Lack of clinical leadership impacts on ability to transform services	Current levels of engagement are good e.g. attenfdance at planned events	Workload pressures can vary unexpectedly and limit capacity particularly in primary care	The CCG can work with localities and networks to encourage engagement at a CCG wide and locality level	High number of stakeholders across the STP could limit consistency of approach with some sectors or places not engaging	2	4	8	23/01/2018	CCG is inversting significantly in clinical leadership at all levels and working with other CCGs to do the same across the STP GP Future Leaders programme has taken place across the STP	2	4	8	Low 4-6	Treat

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P4) Ensure that the CCG's Organisational Development programmes support localities, clinical leaders, staff and the Governing Body to work locally and across the STP on the successful delivery of both strategic objectives and Business As Usual.	Russell Hills	Becky Brewer	P4(c) Changes in the wider strategic context mean that development programmes are overtaken by events.	STP and other strategic change generated centrally	Governing body is limited in scope and influence	Current policy framework (Five Year Forward View Next Steps) is clear. Overarching change framework in place and some policies in place.	Future policy could emerge relatively quickly, e.g. changes in CCG configuration	Maintain close links with partner organisations and develop a shared view of policy dwevelopment / horizon scanning that limits exposure to risk	No ultimate control over central policy or reaction to global events	2	4	8	23/01/2018	Significant board level development in place and significant influence over STP developments. Joint policy framework discussion at JSPF with HR leads.	2	4	8	Moderate 8-12	Tolerate
P4) Ensure that the CCG's Organisational Development programmes support localities, clinical leaders, staff and the Governing Body to work locally and across the STP on the successful delivery of both strategic objectives and Business As Usual.	Russell Hills	Becky Brewer	P4(d) The new joint management arrangements for the three CCGs take time to influence organisational development and realise the benefits of a changed approach.	Joint AO appointment and joint working across three CCGs	Loss of focus on delivery and consequent impact on strategic and operational objectives	Structures in individual organisations are clear	None known	Support agreed approach e.g. management arrangements, thinking on developments; encourage training and joint working	Organisations remain individual legal entities with own culture and history	2	4	8	23/01/2018	New Joint AO appointed and joins early June. Review again for July report. Phase 1 complete - Exec level in place Phase 2 - currently in hand	2	4	8	Moderate 8-12	Tolerate