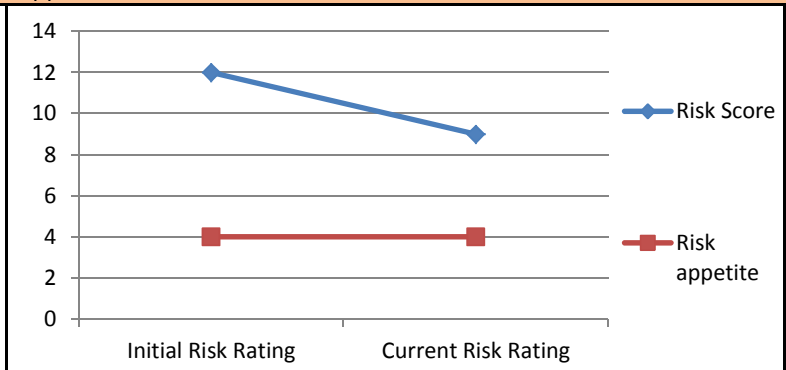
Principal Objective: To ensure there is a sustainable, affordable healthcare system in Sheffield.	**Director Lead:** Idris Griffthis, Director of Health Reform and Transformation
Principal Risk: 4.6 Provider development required to deliver new models of care and achieve CCG stated outcomes does not happen.	**Date last reviewed:** 07 April 2016

Risk Rating:
(likelihood x consequence)
Initial:
3 x 4 = 12
Current:
3 x 3 = 9
Appetite:
1 x 4 = 4



Rationale for current score:
Although work has started, through development of the "vanguard" new models of care bid, much work is needed, across all organisations, to agree how care should be delivered in future.

Rationale for risk appetite:
If we are to achieve our aims, we must work with providers to ensure they are able to deliver the type of support and care that people will need

Existing Controls: *(What are we doing about the risk prior to any new mitigating actions?)*
Development of the vanguard bid
Work with partners to develop 5 year vision as part of the planning process and production of the Sustainability and Transformation Plan
We have now established a new model of care based around neighbourhoods which is being implemented on a phased basis from April 2016

Existing Gaps in Control: *(Where are we failing to put controls in place and what more should be done?)*

Mitigating actions: *(What new controls are to be put in place to address Gaps in Control and by what date?)*

Action	Date
Collaborative Planning process in place for 16/17 which wil result in joined up plans	**Feb - June 16**
Work with partners to develop the 5 year vision	June 2016
Ensure consideration of provider development is part of that work	June 2016
Work with providers to agree new models of care to deliver Active Support and Recovery service, and plan to establish those	1/4/16

Assurances: *(Where should we find the evidence that controls are effective?)* Metrics are being developed and will be overseen by the Sheffield Transformation Board	**Positive Assurance:** *(Provide specific evidence of Assurances)* Implementation of neighbourhood based services with improved support to patients and reduction in acute admissions

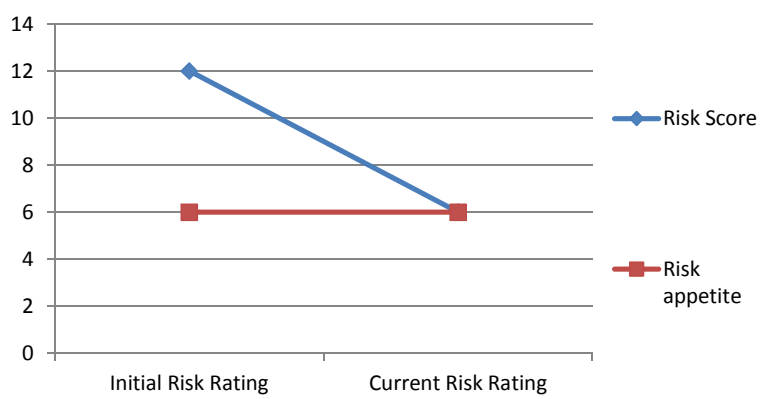
Gaps in assurance: *(Where are we failing to gain evidence that our controls are effective?)*

Principle Risk Reference: 4.6

Principal Objective: Organisational development to ensure the CCG can achieve its aims and objectives and meet national requirements.	**Director Lead:** Idris Griffiths, Director of Transformation and Health Reform
Principal Risk: 5.1 Unable to secure timely and effective commissioning support to enable us to adequately respond and secure delivery to existing and new emerging requirements.	**Date last reviewed:** 07 April 2016

Risk Rating:
(likelihood x consequence)
Initial:
3 x 4 = 12

Current:
3 x 2 = 6
Appetite:
3 x 2 = 6



Rationale for current score:
Current Commissioning Support Arrangements have been reviewed and going through significant change. The commissioning landscape continues to evolve, including integrated commissioning with the LA and the CCG has adopted ambitious commissioning plans to support service transformation. New and emerging initiatives will also need to be responded to as they develop.

Rationale for risk appetite:
Effective commissioning capacity is essential for effective working of CCG . Suite of business cases which identify future commissioning arrangements has now been completed and approved in principle or fully by NHSE. Draft MoUs have now been developed for all shared delivery models.

Existing Controls: *(What are we doing about the risk prior to any new mitigating actions?)* Review of current externally sourced commissioning support arrangements have been reviewed and we are working with commissioning partners across South Yorkshire & Bassetlaw as well as Yorkshire and Humber to ensure sustainable model of commissioning support. New arrangements implemted fully from 31 March 2016 with a combination of in-housing, North East Commissioning and eMBED now providing services	**Existing Gaps in Control:** *(Where are we failing to put controls in place and what more should be done?)* Further work to identify explicit staff within new support arrangements to support mobilisation of new arrangements.

Mitigating actions: *(What new controls are to be put in place to address Gaps in Control and by what date?)*

Action	Date
Develop Implementation plans for the range of outcomes of the IT Procurement Process via the LPF	completed
Proposal for new future commissioning support arrangements to be presented to Governing Body	completed
Implement new arrangements and secure transition from current to future model of provision	completed
Development of a capacity and resourcing approach for internal approvals of commissioning priorities	completed
Identification of CCG requirements for commissioning support services has been completed with majority of business cases for new support arrangements now approved fully or in principle by NHSE. Ongoing procurement for IT and BI services due to be completed September 2015.	completed

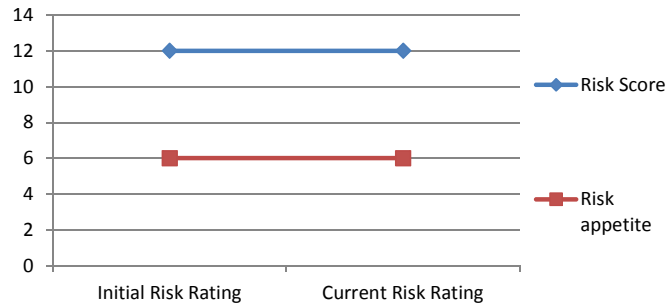
Assurances: *(Where should we find the evidence that controls are effective?)* Governing Body Paper/Minutes CET Approvals Group and Programme Management Delivery Group via Governing Body papers	**Positive Assurance:** *(Provide specific evidence of Assurances)* Minutes of CET & CET Approvals Group and via Governing Body papers

Gaps in assurance: *(Where are we failing to gain evidence that our controls are effective?)*
Currently working with NHSE to implement alternative commissioning support arrangements.

Principle Risk Reference: 5.1

Principal Objective: Organisational development to ensure the CCG can achieve its aims and objectives and meet national requirements.	**Director Lead:** Medical Director (Zak McMurray)
Principal Risk: 5.2 Inability to secure active participation particularly from Member Practices for delivering CCG priorities.	**Date last reviewed:** 06 April 2016

Risk Rating:
(likelihood x consequence)
Initial:
3 x 4 = 12
Current:
3 x 4 = 12
Appetite:
2 x 3 = 6



Rationale for current score:
Active engagement at locality level needed, with clear governance structure into the Clinical Executive Team (CET).
All 88 practices have signed the constitution. Active Clinical Reference Group (CRG).
Comprehensive OD plan in place.

Rationale for risk appetite:
Service transformation requires high take up from clinicians and with mechanisms in place for engagement, as part of our organisational development strategy, will reflect CCG working practices.

Existing Controls: *(What are we doing about the risk prior to any new mitigating actions?)*
Clinical directors now in place with executive role within CET giving clear clinical direction for the organisation. Regular engagement with practices.
OD Strategy includes clinical engagement and member practice engagement at its core.
CCG Structure includes GP involvement at Governing Body and its associated Committees, CET, CRG and H&WB Board. Localities also collaborate through the Citywide Locality Group where membership includes links to the commissioning portfolios and CET. Allocation of an Executive Lead for each locality should improve engagement with the senior management team.
Revised ToR for CLG which is chaired by Chair of the CCG will hopefully strengthen links between localities and CCG.
Existing directors included in practice visits as part of PCC in which CDs involved. Executive leads now attending locality meetings.

Existing Gaps in Control: *(Where are we failing to put controls in place and what more should be done?)*

Mitigating actions: *(What new controls are to be put in place to address Gaps in Control and by what date?)*

Action	Date
CCG Head of Governance & Planning to review the City Wide Localities Group (CLG) and Locality Executive Groups (LEG) ToRs and Committee Structure to ensure that it supports active engagement at localtiy level C/w Locality group meetings now attended by Medical Director and Clinical Directors whenever possible	August 2015
Work with Communicaitons and OD teams to develop robust engagement approaches	Ongoing

Assurances: *(Where should we find the evidence that controls are effective?)*
1) Governing Body Reports 2) OD Steering Group Minutes 3) OD Evaluation Reports to OD Steering Group 4) Response to Election Process 5) OD strategy 6) Minutes from CLG and revised ToR. 7) OD Plan
Minutes from city-wide locality group meetings

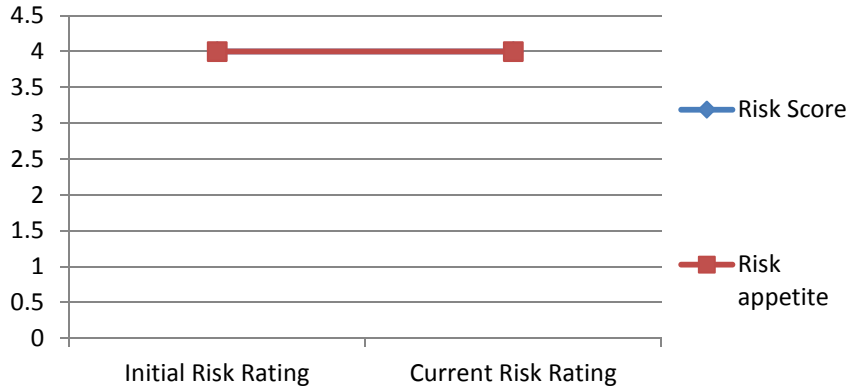
Positive Assurance: *(Provide specific evidence of Assurances)*
Improving Communications and Engagement with Member Practices (July 15)
Equalisation of Core General Practice Finances - EOGB meeting 16.07.15
Positive evaluation from October Members Council Meeting

Gaps in assurance: *(Where are we failing to gain evidence that our controls are effective?)*
none

Principle Risk Reference: 5.2

Principal Objective: Organisational development to ensure the CCG can achieve its aims and objectives and meet national requirements.	**Director Lead: Tim Furness, Director of Delivery**
Principal Risk: 5.3 Inadequate adherence to principles of good governance and legal framework leading to breach of regulations and consequent reputational or financial damage.	**Date last reviewed:** 07 April 2016

Risk Rating:
(likelihood x consequence)
Initial:
1 x 4 = 4
Current:
1 x 4 = 4
Appetite:
1 x 4 = 4



Rationale for current score:
Robust arrangements are now in place.

Rationale for risk appetite:
Authorisation is dependent on robust constitutional arrangement

Existing Controls: *(What are we doing about the risk prior to any new mitigating actions?)*
OD strategy to strengthen governance systems and processes. Stringent policies in place to safeguard against conflict of interest. Explanatory statement now added to committee agendas and explicit discussion regarding percieved conflicts to start meetings

Existing Gaps in Control: *(Where are we failing to put controls in place and what more should be done?)*
no gaps

Mitigating actions: *(What new controls are to be put in place to address Gaps in Control and by what date?)*

Action	Date
Continual review of governance arrangements, especially with regard to integrated commissioning, co-commissioning with NHSE	
establish primary care committee to ensure appropriate mechansims for decisions that can't be taken at GB	in place
review of conflicts of interest policy and procedures, following concerns raised by national issues	in place

Assurances: *(Where should we find the evidence that controls are effective?)*
- Endorsement by NHS E of Constitution
- Forward Planners
- OD event evaluations
- Governance Structure including Members Council and LEGs

Positive Assurance: *(Provide specific evidence of Assurances)*
- Review of constitution
- Management of Conflicts of interest noted at all meetings

Gaps in assurance: *(Where are we failing to gain evidence that our controls are effective?)*
No gaps

Principle Risk Reference: 5.3

Gaps in control and assurance

If your risk has a red box it needs filling in, once you have done so it will turn white. Grey boxes don't need filling in.

Strategic Objective	Principal Risk identified	Risk Owner	Risk Initial Score	Risk current Score	Risk Target or Appetite Score	Are there GAPS in control?	Reason for Gap in Control	Action taken to reduce Gap in Control	Are there Gap in Assurance ?	Reason for Gap in Assurance	Action taken to reduce Gap in Assurance
1. To improve patient experience and access to care	1.1 Insufficient communication and engagement with patients and the public on CCG priorities and service developments, leading to loss of confidence in CCG decisions.	TF	9	9	6	No			no		
	1.2 System wide or specific provider capacity problems emerge to prevent delivery of NHS Constitution and/or NHS E required pledges.	TF	15	15	9	No			No		
2. To improve the quality and equality of healthcare in Sheffield	2.1 Providers delivering poor quality care and not meeting quality targets.	KC	9	6	6	No			No		
	2.2 CCG unable to influence equality of access to healthcare because insufficient or ineffective mechanisms to change	TF	9	9	6	Yes	Current lack of data and contractual levers	Plans in place to improve data collection and ensure equality features in contract negotiations	yes	Controls not yet in place to provide assurance on	Controls being put in place
3. To work with Sheffield City Council to continue to reduce health inequalities in Sheffield	3.1 CCG is unable to undertake the actions, and deliver the outcomes from them, that are set out in the HWB's plan for reducing health inequalities	IG	9	6	3	No			No		
4. To ensure there is a sustainable, affordable healthcare system in Sheffield.	4.1 Financial Plan with insufficient ability to reflect changes to meet demands. **(Currently this is the 2015/16 Plan- A revised assessment is needed for 2016/17 plan.)**	JN	16	9	6	No			No		
	4.2 Risk management and other governance arrangements put in place by CCG and SCC to manage c£270m Better Care Fund budget in 2015/16 prove inadequate	JN	12	12	6	No			No		
	4.3 Budgetary constraints faced by NHS England in particular re specialised services and primary care contracts adversely impact on CCG's ability to implement our plan.	JN	9	6	6	No			No		
	4.4 Inability to secure partnerships with our main providers that help us to deliver our commissioning plans, including QIPP.	TF	9	9	6	Yes	Current lack of formal joint planning process	Joint work on future of health and social care	Yes	Need process in place to report upon, to provide assurance	Being put in place
	4.5 Contractual and financial constraints facing local practices resulting in an inability of some practices to deliver existing non-core work and/or wxpand service provision as envisaged in commissioning plans.	KCl	12	12	6	Yes	Locally Commissioner Service being offered to practices. Funding gaps in practice baselines remain	Develop a Locally Commissioned Service to offer all practices. PCC continue to monitor the	Yes	Process is ongoing with full impact not yet fully assessed	Special cases LCS being offered to identified practices over and above a city wide LCS offer. PCC
	4.6 Provider development required to deliver new models of care and achieve CCG stated outcomes does not happen	IG	12	12	4	No	We have now established a new model of care built arount neighborhoods.	Being developed through integrated commissioning work	No		
5. Organisational development to ensure CCG meets organisational health and capability requirements.	5.1 Unable to secure timely and effective commissioning support to enable us to adequately respond and secure delivery to existing and new emerging requirements.	IG	12	9	6	No			No		
	5.2 Inability to secure active participation particularly from Member Practices for delivering CCG priorities.	ZM	12	12	6	No			No		
	5.3 Inadequate adherence to principles of good governance and legal framework leading to breach of regulations and consequent reputational or financial damage.	TF	4	4	4	No			No		

Introduction **GBAF REFRESH 2016/17**

The Board Assurance Framework aims to identify the principal or strategic risks to the delivery of the CCG's strategic objectives. It sets out the controls that are in place to manage the risks and the assurances that show if the controls are having the desired impact. It identifies the gaps in control and hence the key mitigating actions required to reduce the risks towards the target or appetite risk score. It also identifies any gaps in assurance and what actions can be taken to increase assurance to the CCG.

The table below sets out the strategic objectives lists the various principal risks that relate to them and highlights where gaps in control or assurance have been identified. Further details can be found on the supporting pages for each of the Principal Risks.

Strategic Objective	Principal Risk identified	Risk Owner	Risk Initial Score	Risk current Score	Risk Target or Appetite Score	Are there GAPS in control?	Are there GAPS in assurance?
1. To improve patient experience and access to care (Goals 1, 2,5 & 8)	1.1 Insufficient communication and engagement with patients and the public on CCG priorities and service developments, leading to loss of confidence in CCG decisions and formal challenge.	TF	12	12	6	no	no
	1.2 System wide or specific provider capacity problems in secondary and/or primary care emerge to prevent delivery of NHS Constitution and/or NHS E required pledges including 7 day access	TF	15	15	9	No	No
2. To improve the quality and equality of healthcare in Sheffield (Goals 1, 2, 3, 4 & 6)	2.1 Providers delivering poor quality care and not meeting quality targets.	KeC	12	12	6	No	No
	2.2 CCG unable to influence equality of access to healthcare because insufficient or ineffective mechanisms to change	TF	9	9	6	Yes	yes
	2.3 That the CCG fails to achieve Parity of Esteem for its citizens who experience mental health conditions, so reinforcing their health inequality and life expectancy	ST	16	16	12	Yes	Yes
	2.4 Insufficient resources across health and social care to be able to prioritise and implement the key developments required to achieve our goal of giving every child and young person the best start in life, potentially increasing demand for health and care services.	MA	12	12	9	Yes	yes
3. To work with Sheffield City Council to continue to reduce health inequalities in Sheffield (Goals 3 & 7)	3.1 CCG is unable to undertake the actions, and deliver the outcomes from them, that are set out in the HWB's plan for reducing health inequalities, eg due to financial constraints.	IG	9	9	6	Yes	yes
4. To ensure there is a sustainable, affordable healthcare system in Sheffield. (Goal 2, 5, 7 & 8)	4.1 Financial Plan with insufficient ability to flex to meet in year demands and at same to meet the NHSE business rules for 2016/17	JN	16	16	9	No	No
	4.2 Risk management and other governance arrangements put in place by CCG and SCC to manage the BCF prove inadequate to deliver our integrated commissioning programme and meet our joint efficiency challenges	JN	9	9	6	No	No
	4.3 Inability to deliver the QIPP (efficiency) savings plan of £19.5m due to lack of internal capacity and lack of engagement by our key partners	QIPP director for AO	16	16	8	No	No
	4.4 Inability to secure partnerships with secondary and primary care providers to deliver the Sheffield Transformation Programme in particular our out of hospital strategy.	IG	9	9	6	Yes	Yes

	4.5 Inability to agree and progress service changes across the South Yorkshire and Bassetlaw Sustainability and Transformation Programme (STP) footprint at a pace which supports delivery of collective efficiency challenge	MR	16	16	8	No	No
5. Organisational development to ensure CCG meets organisational health and capability requirements. (Goals 1 - 8)	5.1 Inability to maximise the anticipated benefits of Co-commissioning of GP led primary care services	KaC	12	12	6	no	no
	5.2 Unable to secure timely and effective commissioning support to enable us to adequately respond and secure delivery to existing and new emerging requirements. Quality of externally purchased commissioning support (IT and data management) falls below required levels	IG	12	12	6	No	No
	5.3 Inability to secure active engagement/participation between Member Practices and relevant CCG teams which may result in not achieving CCG priorities.	ZM	12	12	6	No	No
	5.4 Inadequate adherence to principles of good governance and legal framework leading to breach of regulations and consequent reputational or financial damage.	TF	8	8	4	No	No

The Risk Ratings used in the Assurance Framework are based on the following risk stratification table:

Risk Matrix		Likelihood				
		-1 Rare	-2 Unlikely	-3 Possible	-4 Likely	-5 Almost certain
Consequence	-1 Negligible	1	2	3	4	5
	-2 Minor	2	4	6	8	10
	-3 Moderate	3	6	9	12	15
	-4 Major	4	8	12	16	20
	-5 Extreme	5	10	15	20	25

1 to 3	Low
4 to 9	Medium
10 to 14	High
15 to 19	Very High (Serious)
20 to 25	Critical

8 Goals for Commissioning Strategy

1. Deliver timely and high quality care in hospital for all patients and their
2. Become a person-centred city: promoting independence for our citizens and supporting them to take control of their health and health
3. Tailor services to support a reduction in health inequalities across the Sheffield Populction
4. Integration o f physical and mental health, ensurig parity of esteem for people with mental health needs
5. Support people living with and beyond life threatening or long term cor
6. Give every child and young person the best start in life
7. Prevent the early onset of avoidable disease and premature deaths
8. We will work in collaboration with partners for sustainable care models by playing an active role in regional sustainability and be recognised as a system leader for public sector reform.