NHS
Heywood, Middleton and Rochdale
Clinical Commissioning Group

PART 1 GOVERNING BODY 2022/23

Date of Meeting:	20 May 2022
Agenda Item:	3.3
Subject:	Corporate Risk & Assurance Framework
Reporting Officer:	Claire Richardson
Aim of Paper	To outline position on the overarching risks across the seven Strategic Objectives

Governance route prior to Governing Body	**Meeting Date**	**Objective / Outcome**
Governing Body - Statutory		
Audit Committee - Statutory		
Remuneration Committee - Statutory		
Primary Care Commissioning Committee - Statutory		
Clinical and Professional Advisory Panel		
Information Governance Management Group		
Locality Engagement Group		
Patient and Public Engagement Committee		
Quality and Safeguarding Committee / Group		
Integrated Commissioning Board (RBC/HMR CCG)		
Strategic Place Board (previous HWBB – RBC)		
Other:		

Governing Body Resolution Required:	For Approval

Recommendation: To approve the Corporate Risk and Assurance Framework

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Link to Strategic Objectives (SO):	
SO1: To be a high performing CCG, deliver out statutory duties and use our available resources innovatively to deliver the best outcomes for our population	**Yes**
SO2: To deliver on the outcomes of the Locality Plan in respect of **Prevention and Access** (Prevention and Self Care)	**Yes**
SO3: To deliver on the outcomes of the Locality Plan in respect of **Neighbourhoods & Primary Care (**Getting help in the Community)	**Yes**
SO4: To deliver on the outcomes of the Locality Plan in respect of **In Hospital - Planned** (Getting more help)	**Yes**
SO5: To deliver on the outcomes of the Locality Plan in respect of **In Hospital – Urgent Care (**Getting more help)	**Yes**
SO6: To deliver on the outcomes of the Locality Plan in respect of **Children, young people and families**	**Yes**
SO7: To deliver on the outcomes of the Locality Plan in respect of **Mental Health**	**Yes**

RISK LEVEL (To be reviewed in line with the Risk Policy)
RAG Status: *Not applicable*
Comments: *Not applicable*

CONTENT APPROVAL / SIGN OFF
The contents of this paper have been reviewed and approved by: Director of Integrated Systems Development - Sandra Croasdale
Clinical Content signed off by: Not applicable
Financial content signed off by: Not applicable

Clinical Engagement taken place: Not Applicable
Patient and Public Involvement: Not Applicable
Patient Data Impact Assessment: Not Applicable
Equality Analysis / Human Rights Assessment Completed: Not Applicable

EXECUTIVE SUMMARY

1. Purpose

To provide an update on the Heywood, Middleton & Rochdale Clinical Commissioning Group's Corporate Risk and Assurance Framework

2. Recommendation

To approve the Corporate Risk and Assurance Framework

3. Corporate Risk & Assurance Framework Overview

The Corporate Risk and Assurance Framework logs risks across the CCG and provides details on the mitigating action/controls and assurance/gaps in assurance. This report provides an overview of

these risks with a particular focus on those with a residual risk score of 15 or above (RAG Red) and/or risks with limited assurance.

The risks contained within this paper go through a rigorous development/ review process at each of the LCO Programme Boards and Subcommittee Groups that have been established as part of the development of our locality construct.

3.1 Inherent Risk Score Overview

The table below summarises the current risks by Strategic Objective and Inherent score. There are 71 risks in total, of which, 42 have inherent scores between 1-14 and are RAG rated as green or amber, 29 risks have an inherent score of 15 or more.

Strategic Objective	2	3	4	6	8	9	10	12	15	16	20	25	Total
Strategic Objective 1: To be high performing, deliver our statutory duties and use our available resources innovatively to deliver the best outcomes for our population	1	2	4	1	3	7		5	3	5	4	2	**37**
Strategic Objective 2: To deliver on the outcomes of the Locality Plan in respect of P&A (Prevention and Self Care)						2						1	**3**
Strategic Objective 3: To deliver on the outcomes of the Locality Plan in respect of Neighbourhoods and Primary Care		1			1	5	1	5	1	2	1		**17**
Strategic Objective 4: To deliver on the outcomes of the Locality Plan in respect of in hospital - Planned (Getting more help)						1				1	3		**5**
Strategic Objective 5: To deliver on the outcomes of the Locality Plan in respect of In Hospital – Urgent Care (Getting more help)									1				**1**
Strategic Objective 6: To deliver on the outcomes of the Locality Plan in respect of Children, young people and families						3				3	2		**8**
Total	1	3	4	1	4	18	1	10	5	11	10	3	**71**
	9				33				29				

3.2 Residual Risk Score Overview – Risks with a score of 15 or more

The following table shows residual risk scores for the 29 risks that have an inherent score of 15 or more.

Strategic Objective	4	6	8	9	12	15	16	20	Total
Strategic Objective 1: To be high performing, deliver our statutory duties and use our available resources innovatively to deliver the best outcomes for our population			1	3	7		1		**12**

Strategic Objective 2: To deliver on the outcomes of the Locality Plan in respect of P&A (Prevention and Self Care)								2	**2**
Strategic Objective 3: To deliver on the outcomes of the Locality Plan in respect of Neighbourhoods and Primary Care				3	1				**4**
Strategic Objective 4: To deliver on the outcomes of the Locality Plan in respect of in hospital - Planned (Getting more help)				2		1	1		**4**
Strategic Objective 5: To deliver on the outcomes of the Locality Plan in respect of In Hospital – Urgent Care (Getting more help)						1			**1**
Strategic Objective 6: To deliver on the outcomes of the Locality Plan in respect of Children, young people and families		1	1	2	2				**6**
Total	**0**	**1**	**2**	**10**	**10**	**2**	**2**	**2**	**29**
	1		**22**			**6**			

Following the mitigating actions/controls being put in place 5 risks continue to have a risk score of 15 or more. These are the highest risk areas:

SO4-010 **System impact of increased waiting times for treatments**

If we fail to reduce waiting times across the system, THEN patients are at risk of both harm or poorer outcomes and increased cost to the system due to increased acuity at the time of treatment.

Controls:

1. Waiting list recovery programme established.
2. Waiting list is being monitored and reported through the performance report
3. Working with Independent Sector providers and the Northern Care Alliance to reduce waiting lists using the Independent Sector Capacity Framework for transferring patients
4. HMR continues to work with the GM Elective Reform Recovery and Restoration Operations Group on identified Waiting List initiatives
5. Quality & Safeguarding consideration for all patients. Harm reviews to be undertaken for all patients and prioritised accordingly.
6. Engaging with the General Public - GM have established a While You Wait website, which provides information on how to manage conditions and wellbeing whilst waiting for treatment.
7. Engagement with Individuals - GP practices now have information to relay to patients about average length of wait which they communicate to patients directly

SO2-008 **Exacerbated health inequalities**

IF we do not have adequate plans in place to address increasing health inequalities due to the impact of Covid-19 (specifically unfair and unjust inequality), then the outcomes for our residents will be negatively impacted.

Controls

1. A full programme of work is underway in regards to the management of waiting lists through the LCO programmes in order to address inequalities in access to health and care services.
2. LCO Business Plan developed which details our system plans for reducing inequality
3. Cancer and CVD programme being established
4. Prevention Strategy developed

SO2-009	**Increased poverty and the impact on inequalities and health outcomes** Levels of poverty are increasing significantly due increases in fuel prices and cost of living and global instability. IF we do not have adequate plans in place to mitigate these issues (especially as winter approaches and fuel prices increase further in October) THEN inequalities will broaden and the outcomes for our residents will be negatively impacted. This could also impact health services, specifically in relation to respiratory and other illnesses **Controls** 1. Developed a Public Health Directorate Plan for 22/23, that focusses on addressing the longer-term impact of the pandemic, including population health, wider determinants, and inequalities. This will underpin the majority of our work over the next 12 months. 2. A "bounce back" plan has been developed. This utilises additional funding reviewed from covid 3. A community recovery plan has been developed that includes housing, food, advice, economic support and digital support. 4. A task and finish group is being established to develop a specific system plan.
SO4-009	**Diagnostic Waits** IF diagnostic waits continue to increase THEN this will impact on patient outcomes, as patients become more unwell whilst waiting and this could lead to a further delay in treatment. **Controls** 1. Best Time Pathways in place (Nurse-led triage) for Upper Gastrointestinal (GI), Colorectal and Lung. 2. HMR CCG continues to work with the GM Elective Reform Implemented 'Straight to CT' (Computerized Tomography) for abnormal Lung X-Ray 3. GP Direct Access Diagnostics (DAD) for NOUS, Head and Neck MRI and Audiology now live - Community Based Service releasing capacity and secondary care 4. Phase One While You Wait Website now live 5. Implemented Blood Pressure Monitors at Home Scheme
SO5-004	**Constitutional Performance for A&E - specifically in relation to 12 hour waits** IF the main NHS constitution performance measures for: a) 4 Hour Waiting Time b) 12 Hour Trolley Waits c) Ambulance Response Times for Cat 3 Calls d) Hospital Handover Delays > 30 mins 12-hour trolley waits in A&E are not achieved. THEN finances, reputation and patient outcomes will be impacted resulting in scrutiny from external bodies such as NHS England and Greater Manchester Health & Social Care Partnership **Controls** 1. System pressures meeting in place to support with hospital flows and discharges via Integrated discharge team (IDT) 2. CCG quality team investigating new breaches with improvement plan in place at the Royal Oldham Hospital where a large number of 12-hour breaches occurred. 3. Same Day Emergency Access pathways into Rochdale Infirmary in place for HMR patients for neighbouring Royal Oldham and Fairfield

General Hospital, with option to support North East Section patients during time of surges
4. Communication and dialogue with the care home sector in place with active promotion of 2hr community response (Rapid Response and Rochdale SDEC)
5. Processes and teams in place to improve discharges via Home in a Day, Discharge to Assess, & patient transport services
6. NCA Triple Surge' Strategy in place for each care organisation

SO1-049 **Impact of reduced workforce capacity on the delivery of outcomes**

There are several uncertainties which could impact resource:
1. Locality construct and where staff will be employed (losing staff to GM or staff leaving as a result of uncertainty)
2. Pressures within services (prioritising finite resources and the impact on service transformation)
3. The on-going impact of COVID-19 (staff illness and self-isolation)
4. Inability to recruit, leading to staff vacancies across the system.

IF any of these result in reduced capacity and/or losing staff within the system THEN this will impact our ability to deliver the outcomes described within our Locality Plan.

Controls:

Locality construct:
1. Regular updates provided at staff briefing sessions.
2. Regular briefings within teams
3. Communications and engagement linking in with GM to ensure consistent messaging include frequently asked questions
4. Continue to be fully engaged in GM construct work - The development of the locality construct is underway with clear links and reporting into the System Board and Integrated Commissioning Board with full participation from across the health and care system.
5. National HR Framework received and being worked through.

Pressures within services
1. LCO Mandates in implementation - service transformation to manage demand
2. Business continuity plans in place

Impact of COVID-19
1. Continue to roll out vaccination and boosters to all health and care staff

Inability to recruit
1. System workforce strategy and plan in development with dedicated resource identified to support development

3.3 Changes since the last report to Governing Body in March

Ref	Risk Title	Risk Description	Reason for change	Previous Score	Current Score	Change
SO6 - 007. c	Escalating waiting times for autism assessment (Healthy Young Minds – children aged over 5 years)	IF the demand for Autism Diagnostic Observation Schedule (ADOS) assessments remain high for children aged over 5. THEN this will delay timely diagnosis/support and is likely to negatively impact their	There has been a significant improvement in waiting list for ADOS Assessments which has been supported by weekend clinics and further improvements are expected.	16	9	↓ Residual score reduced. 16 to 9

		education, health and life chances.				
SO1 -058	Inability to financially plan beyond 22/23	IF there continues to be uncertainty regarding the financial decision-making responsibilities at locality and GM level. THEN we will not have the level of flexibility needed to reallocate funding, which could impact planning of service provision in the locality.	The CCG submitted a final 22/23 financial plan at the end of April. The financial plan submitted is a breakeven position. There is still a risk of the delivery of the plan but there are processes in place to achieve the plan.	12	8	↓ Residual score reduced from 12 to 8

3.4 New risk added since the last report to Governing Body in March

Ref	Risk Title	Risk Description	Inherent Score	Current Score
SO1 -070	Uncertainty of the locality's accountability for performance against the activity plan submission	IF the planning activity submission information and assumptions are not available to localities because plans have been aggregated across GM and responsibility for delivering on plans is not clear THEN this will mean there is continued uncertainty as to whether the locality or GM is accountable for performance against the activity plans.	16	12
SO2 -009	Increased poverty and the impact on inequalities and health outcomes	Levels of poverty are increasing significantly due increases in fuel prices and cost of living and global instability. IF we do not have adequate plans in place to mitigate these issues (especially as winter approaches and fuel prices increase further in October) THEN inequalities will broaden and the outcomes for our residents will be negatively impacted. This could also impact health services, specifically in relation to respiratory and other illnesses	20	20

4. CCG Closedown Risks

The table below shows the risk that are related to the closedown of the CCG. These are included for information as no risks currently require escalation.

Ref	Risk Title	Risk Description	Inherent Score	Residual Score
SO1-058	Inability to financially plan beyond 22/23	IF there continues to be uncertainty regarding the financial decision-making responsibilities at locality and GM level. THEN we will not have the level of flexibility needed to reallocate funding, which could impact planning of service provision in the locality.	20	8
SO1-046	Establishment of GM ICS and Rochdale Locality Construct	IF we do not establish clear lines of accountability and responsibility within our locality operating model that ensures adherence to statutory duties, supports enabling functions and that aligns with GM ICS THEN we will be unable to effectively deliver the outcomes described in the locality plan.	16	12

SO1-066	CCG Closedown - Electronic Management	IF there is not a network or shared repository for the storage of records, including an electronic records management file structure and adequate file plans in place for digital repositories. THEN this will lead to loss of assets or inability to access documents.	16	9
SO1-068	CCG Closedown - Patient facing record keeping.	IF there is not agreed funding and processes in place to transfer, store and retain legacy information for patient facing care records*. THEN there will be limited assurance and clarity where existing and future records will be kept and maintained. *records need to be kept according to the NHS Records Management Codes of Practice	16	9
SO1-048	Continuity of Quality, Safety and Safeguarding after CCG closedown in July 2022	IF Quality, Safety and Safeguarding functions are delivered across the Integrated Care System (ICS) footprint following the closure of the CCG, THEN there will be a reduction in placed based oversight and assurance at a local level.	16	12
SO1-070	Uncertainty of the locality's accountability for performance against the activity plan submission	IF the planning activity submission information and assumptions are not available to localities because plans have been aggregated across GM and responsibility for delivering on plans is not clear THEN this will mean there is continued uncertainty as to whether the locality or GM is accountable for performance against the activity plans.	16	12
SO1-069	Losing staff due to uncertainty around the development of the GM ICS	IF staff decide to leave employment due to the uncertainty around the development of the GM ICS THEN this will impact our ability to deliver our Locality Construct.	12	12
SO1-057	Management of the Implementation of the medicines optimisation team into the NCA	IF the Care Organisation fails to manage the Implementation of the medicines optimisation team into the NCA THEN this is a risk both for financial delivery of the budget and in the effective delivery of care.	12	9
SO3-024	Transition to Integrated Commissioning System within Primary Care	IF there is an organisational restructure process and this does not have clear guidance for organisation e.g. CCG and GP Federation THEN the transition will result in delays and uncertainly which could impact on the planning, commissioning and delivery of local commissioned services (LCS)and GP contract management.	9	6
SO1-063	Medicines Optimisation Team-workforce	If members of the Medicines Optimisation team leave the CCG THEN recruitment will need to take place to fill permanent positions required to complete all duties.	8	3

5. Overview of Appendices

The Corporate Risk & Assurance Framework appendices that follow outline the risks in more detail including the assurances that are in place: Where risks are defined as having limited assurance, we continue to work with risk owners to reassess the assurance level.

1 **Appendix I** - extract of the Assurance Framework and only contains risks with an inherent and residual risk score of 15 or more (highest risk).

2 **Appendix II** - extract of the Assurance Framework and only contains risks with an inherent risk score of 15 or more and a residual risk of 15 or less.

3 **Appendix III** - Full copy of the Corporate Risk & Assurance Framework which lists all risks regardless of the risk score (provided for information/reference)

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Appendix I - Assurance Framework and only contains risks with an inherent and residual risk score of 15 or more (highest risk).

					Inherent								Residual		
Ref	**Risk Title**	**Strategic Objective**	**Risk Description**	**Risk Owner**	**Likelihood**	**Impact**	**Score**	**Mitigations in place already**	**Actions to further mitigate**	**Gaps in Controls**	**Assurance**	**Gaps in Assurance**	**Assurance Level**	**Likelihood**	**Impact**	**Score**
SO2-008	**Exacerbated health inequalities**	Strategic Objective 2: To deliver on the outcomes of the Locality Plan in respect of P&A (Prevention and Self Care)	IF we do not have adequate plans in place to address increasing health inequalities due to the impact of Covid-19 (specifically unfair and unjust inequality), then the outcomes for our residents will be negatively impacted	Kuiama Thompson / Anthony Threlfall	5	5	**25**	1. A full programme of work is underway in regards to the management of waiting lists through the LCO programmes in order to address inequalities in access to health and care services. 2. LCO Business Plan developed which details our system plans for reducing inequality 3. Cancer and CVD programme being established 4. Prevention Strategy developed	Continue working to address Inequalities in outcomes especially by ensuring equitable access to services	Cannot control the long-term sequential impact of the pandemic. E.g. we know that children have been impacted long term in terms of their development. However, we do not know the long-term effect of this. Also, the long-term impact of long covid.	1. People and place partnership 2. LCO SMT 3. LCO Exec 4. LCO Board 5. System Board	None	Significant	5	4	**20**
SO4-010	**System impact of increased waiting times for treatments**	Strategic Objective 4: To deliver on the outcomes of the Locality Plan in respect of in hospital - Planned (Getting more help)	IF we fail to reduce waiting times across the system THEN patients are at risk of both harm or poorer outcomes and increased cost to the system due to increased acuity at the time of treatment.	Steve Taylor	5	4	**20**	1. Waiting list recovery programme established within year 2 of LCO mandate. 2. Waiting list is being monitored and reported through the performance report 3. Working with Independent Sector providers and the trust to reduce waiting lists using the Independent Sector Capacity Framework for transferring patients 5. HMR continues to work with the GM Elective Reform Recovery and Restoration Operations Group on identified Waiting List initiatives 6. Quality & Safeguarding consideration for all patients. Harm reviews to be undertaken for all patients and prioritised accordingly. 7. Engaging with the General Public - GM have established a While You Wait website, which provides information on how to manage conditions and wellbeing whilst waiting for treatment. 8. Engagement with Individuals - GP practices now have information to relay to patient about average length of wait which they communicate to patients directly.	1. Working with the providers to support appropriate prioritisation of waiting list. 2. Awaiting national guidance on patient choice. 3. Further work on communications required 4. Development of Equality Audit to support review of the waiting list (linking with Public Health) 5. Establish ' GM My Planned Care' Programme **6. Engagement with general Public -** Developing stronger links with community facing organisations and VCSE sector to disseminate messaging. **7. Engagement with individuals - Working** with providers to confirm arrangements for contacting individuals on the waiting list (in line with planning guidance). 8. Developing the Prehabilitation Offer to inform people how to prepare for and be fit for surgery.	Activity requirements in relation to the operating plan are being met but this is not enough activity to reduce the waiting times. Detailed plans to be developed for all specialties to support system planning. No cross-system data on community waits	**Internal Assurance:** 1. Reporting through system board and CCG assurance - FPR, ICB and Governing Body. 2. Reporting through LCO assurance - LCO Planned Care Programme Board, LCO Exec and LCO Board **External Assurance:** 1. GM Elective Care Recovery and Reform Programme hosted by Stockport FT	None	Significant	4	4	**16**
SO2-009	**Increased poverty and the impact on inequalities and health outcomes**	Strategic Objective 2: To deliver on the outcomes of the Locality Plan in respect of P&A (Prevention and Self Care)	Levels of poverty are increasing significantly due increases in fuel prices and cost of living and global instability. IF we do not have adequate plans in place to mitigate these issues (especially as winter approaches and fuel prices increase further in October) THEN inequalities will broaden and the outcomes for our residents will be negatively impacted. This could also impact health services, specifically in relation to respiratory and other illnesses	Kuiama Thompson / Anthony Threlfall/ John Rooney	5	4	**20**	1. Developed a Public Health Directorate Plan for 22/23, that focusses on addressing the longer-term impact of the pandemic, including population health, wider determinants, and inequalities. This will underpin the majority of our work over the next 12 months. 2. A "bounce back" plan has been developed. This utilises additional funding reviewed from covid 3. A community recovery plan has been developed that includes housing, food, advice, economic support and digital support.	1. Fuel Poverty - Scheme to be developed to support warm homes initiative. Will require moving finances away from health. A business case needs to be developed to support this 2. Food - Business Plan to be developed for future of food solutions network to provide sustainable access to free and low cost food. 3. Community wealth strategy to be developed. A review is currently taking place to support this.	1. No anti-poverty plan for the system. 2. Lack of National funding availability 3. Poor housing insulation impacting fuel usage	Strategic 1.Health & Wellbeing Board 2.LCO SMT 3.LCO Exec 4.LCO Board 5.System Board 6.Strategic Housing Board Operational 7. Community Recovery Group	None	Significant	5	4	**20**
SO1-049	**Impact of reduced workforce capacity on the delivery of outcomes**	Strategic Objective 1: To be high performing, deliver our statutory duties and use our available resources innovatively to deliver the best outcomes for our population	There are several uncertainties which could impact resource: 1. Locality construct and where staff will be employed (losing staff to GM or staff leaving as a result of uncertainty) 2. Pressures within services (prioritising finite resources and the impact on service transformation) 3. The on-going impact of COVID-19 (staff illness and self-isolation) and mandatory vaccination requirements 4. Inability to recruit, leading to staff vacancies across the system.	Rosemary Barker / Clare Nott	4	4	**16**	**Locality construct:** 1. Regular updates provided at staff briefing sessions. 2. Regular briefings within teams 3. Communications and engagement linking in with GM to ensure consistent messaging include frequently asked questions 4. Continue to be fully engaged in GM construct work - The development of the locality construct is underway with clear links and reporting into the System Board and Integrated Commissioning	**Locality Construct:** 1. Continue to be fully engaged in GM construct work 2. Further develop locality construct 3. Continue to engage will all staff using all available methods 4. Mapping exercise to be completed for all staff in line with GM construct **Pressures within services** 1. Agree a set of principles to inform prioritisation if needed.	Locality Construct: 1. Understanding of implications is currently limited but developing through the GM and locality construct work.	1. Gold and Silver Groups are in place 2. Reports are regularly provided to Leadership teams and Governing Body 3. Reporting through LCO Board and System Board 4. Management through Workforce subgroup	None	Significant	4	4	**16**

					Inherent								Residual		
Ref	Risk Title	Strategic Objective	Risk Description	Risk Owner	Likelihood	Impact	Score	Mitigations in place already	Actions to further mitigate	Gaps in Controls	Assurance	Gaps in Assurance	Assurance Level	Likelihood	Impact	Score
			IF any of these result in reduced capacity and/or losing staff within the system THEN this will impact our ability to deliver the outcomes described within our Locality Plan.					Board with full participation from across the health and care system. 5. National HR Framework received and being worked through. **Pressures within services** 1. Winter plan has been developed and in the process of implementation to support increases in demand 2. LCO Mandates in implementation - service transformation to manage demand 3. Business continuity plans in place 4. Risk fully managed as part of risk 001a. **Impact of COVID-19** 1. Continue to roll out vaccination and boosters to all health and care staff 2. Outbreak plan implementation to reduce transmission	2. Streamline programme delivery so resource can be more effectively utilised across the programmes **Impact of COVID-19** 1. Respond to national policies as they develop. 2. Maintain outbreak plan 3. Continuation of vaccination programme and determine impact on workforce of mandatory vaccinations"						
SO5-004	**Constitutional Performance for A&E - specifically in relation to 12 hour waits**	Strategic Objective 5: To deliver on the outcomes of the Locality Plan in respect of In Hospital – Urgent Care (Getting more help)	IF non-compliance with the NHS Constitution performance measures a) 4 Hour Waiting Time b) 12-Hour Trolley Waits c) Ambulance Response Times for Cat 3 Calls d) Hospital Handover Delays > 30 mins 12-hour trolley waits in A&E) continues THEN there is a risk that patient outcomes may be impacted.	Nadia Baig/Shaju Ahmed	5	4	**15**	1. Same Day Emergency Care (SDEC) pathways into Rochdale Infirmary in place for HMR patients. During surge support is provided for neighbouring Royal Oldham Hospital (ROH) and Fairfield General Hospital (FGH), with option to support North East Sector (NES) patients during time of surges. 2. Communication and dialogue with the care home sector in place with active promotion of 2hr community response (Rapid Response and Rochdale SDEC) and 24/7 Single Point of Access now operating for Rapid Response for care homes. The Enhanced Care Homes Direct Enhanced Service (DES) also supporting with weekly check-in via Primary Care Networks (PCNs). 3. Processes and teams in place to improve discharges via Home in a Day, Discharge to Assess, & patient transport services 4. Greater Manchester Clinical Assessment Service (GMCAS) pulling suitable 999 /111 patients from the stack reducing demands on North West Ambulance Service (NWAS) and Accident & Emergency (A&E) departments. 5. Pre-Emergency Department (Pre ED) streaming in place at both ROH and FGH redirecting lower acuity HMR patients to suitable primary, community services or Rochdale Urgent Treatment Centre (UTC) 6. PCN Hub at Whitehall Street and Phoenix offering additional primary care appointments during core hours. PCN hub has been running additional weekend clinics throughout January. In addition, GP practices are offering additional appointments as part of Winter Access Funds. 7. CCG quality team continually reviewing and investigating new breaches by ensuring 48-hour breach reports are submitted and any duty of candour is undertaken. A NES	1. Performance across all Constitution areas monitored regularly via Governing Body & ICB. 2. Further analysis to be provided regularly to various internal committees and urgent care MDTs. 3. Planning Guidance for 2022-23 sets out the priority to eliminate 12 hour waits in E.Ds. Currently reviewing if any further actions required. 4. Develop plans to increase usage of virtual wards via SDEC as well as opportunities to increase usage of Rochdale SDEC rather than patients conveying at ROH and FGH SDEC services. 5. Development of a system wide admission avoidance scheme to support care homes. 6. Planning guidance sets out requirements to improve against all constitutional performance measures. This will be a focus at GM level for 2022/23. 7. Royal Oldham and Fairfield remedial action plan to help better manage ambulance handover times and targets. We will continue to monitor and review data.	HMR patients attending Oldham and Bury. Improvement plans at GM level for ambulance performance. Need more oversight.	LCO UEC Programme Board GM Discharge meetings Governing Body ICB, MDT	None	Significant	5	3	**15**

					Inherent									Residual		
Ref	Risk Title	Strategic Objective	Risk Description	Risk Owner	Likelihood	Impact	Score	Mitigations in place already	Actions to further mitigate	Gaps in Controls	Assurance	Gaps in Assurance	Assurance Level	Likelihood	Impact	Score
								standardised reporting form has been developed. 8. HMR Urgent Care Programme Board and Clinical Governance Group meetings monthly to discuss themes and areas which require support and focus. 9. Direct SDEC pathways for NWAS paramedics are now in place at Oldham. 10. Utilisation Management (UM) report on 12-hour waits shared with Urgent Care Programme Board.								
SO4-009	**Diagnostic Waits**	Strategic Objective 4: To deliver on the outcomes of the Locality Plan in respect of in hospital - Planned (Getting more help)	IF diagnostics waits continue to increase THEN this will impact on patient outcomes, as patients become more unwell whilst waiting and this could lead to a further delay in treatment.	Nadia Baig	5	4	20	1.Time Pathways in place (Nurse-led triage) for Upper Gastrointestinal (GI), Colorectal and Lung. 2.HMR CCG continues to work with the GM Elective Reform 3. Implemented 'Straight to CT' for abnormal Lung X-Ray 4.GP Direct Access Diagnostics (DAD) for NOUS, Head and Neck MRI and Audiology now live - Community Based Service releasing capacity and secondary care 5.Phase One While You Wait Website - now live 6.Implemented Blood Pressure Monitors at Home Scheme	1. Development of While You Wait Programme (System Wide) 2. HMR to engage with GM Echo elective wait programme. 3. HMR to work with local diagnostic (Echo) provider to develop a waiting list initiative 4. Implement 'Straight to CT' for abnormal Lung X-Ray 5. HMR CCG to work with NCA on establishment of Community Diagnostic Hub (in Royton)	1. Performance Reporting with the trust has been stood down. However, we continue to monitor locally with our BI Partners and independent sector. 2. Cancer patients are currently being prioritised over RTT patients on the Radiology Waiting List	**Internal Assurance:** 1. Planned Care Programme Board 2.Monthly MDT meetings to discuss specific areas of under-performance 3. Performance Reports supplied to FPR and Governing Body 4. Routinely discussed at Governing Body **External Assurance:** 5. GM Elective Reform Recovery and Restoration Operations Group	None	Significant	5	3	15

Appendix II: Assurance Framework with inherent risk score of 15 or more and a residual risk score of 14 or less

					Inherent									Residual		
Ref	Risk Title	Strategic Objective	Risk Description	Risk Owner	Likelihood	Impact	Score	Mitigations in place already	Actions to further mitigate	Gaps in Controls	Assurance	Gaps in Assurance	Assurance Level	Likelihood	Impact	Score
SO1-046	**Establishment of GM ICS and Rochdale Locality Construct**	Strategic Objective 1: To be high performing, deliver our statutory duties and use our available resources innovatively to deliver the best outcomes for our population	IF we do not establish clear lines of accountability and responsibility within our locality operating model that ensures adherence to statutory duties, supports enabling functions and that aligns with GM ICS THEN we will be unable to effectively deliver the outcomes described in the locality plan.	Claire Richardson/ Steve Taylor	4	4	16	1. The development of the locality construct is underway with clear links and reporting into the HMR Integrated Commissioning Board with full participation from across the health and care system. 2. The locality construct work is being undertaken with a full knowledge of plans at a Greater Manchester level and key individuals collaborating on the GM proposals are also informing our local work. 3. Finance, Performance and Risk, Quality and Safety and Workforce subcommittees are now in place and reporting to LCO Board and Shadow System Board. 4.Rochdale System Operating Model now agreed through LCO Board, Shadow System Board and ratified through the Integrated Commissioning Board 10. LCO Business Plan established to ensure focus on delivery across the system	1. Continued communication and ensuring the Rochdale locality position is reflected in what is proposed at GM - ensuring local services stay locally commissioned 2. Partnership agreements as set out in the Operating Model to be developed 3. LCO Business plan refresh to take account of NHS planning guidance 4. Agree reporting arrangements from sub committees to LCO Board 5. Further development work for Operating Model to include GM delegations (when known), staffing arrangements and financial arrangements	1. Spatial framework is not yet published - this will inform further planning. Current planning based on assumptions 2. Process for managing conflicts of interest needs to be developed	Reporting through: 1.ICB/ System Board 2. LCO Board 3. CCG Governing Body	None	Significant	3	4	12
SO6-054	**Children's Waiting Times**	Strategic Objective 6: To deliver on the outcomes of the Locality Plan in respect of	Covid 19 has increased the demand for children's services which has resulted in growing waiting lists IF we fail to reduce these	Steve Kay/ Charlotte Mitchell	5	4	20	1. Funding for waiting lists backfill 2021 £250k (recruitment challenges) 2. Monthly quality recovery challenge and support meetings. 3. 2022/23 agreed skill mix funding to increase admin capacity, recruit training posts and develop	Define the current position and specific system children's plans	None	**Internal Assurance:** 1. Reporting through system board and CCG assurance - FPR, ICB and Governing Body. 2. Reporting through LCO	None	Significant	4	3	12

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		Children, young people and families	waiting times and provide support to those children waiting THEN this could negatively impact children's long term health inequalities and life outcomes.					whilst you wait initiatives to support families. 4. Commission of IMPOWER to review and re-design integrated therapeutic pathways for OT and SLT.			assurance - LCO Planned Care Programme Board, LCO Exec and LCO Board **External Assurance:** 1. GM Elective Care Recovery and Reform Programme hosted by Stockport FT					
SO1-068	**CCG Closedown - Patient facing record keeping.**	Strategic Objective 1: To be high performing, deliver our statutory duties and use our available resources innovatively to deliver the best outcomes for our population	IF there is not agreed funding and processes in place to transfer, store and retain legacy information for patient facing care records*. THEN there will be limited assurance and clarity where existing and future records will be kept and maintained. *records need to be kept according to the NHS Records Management Codes of Practice	Chris Upton/Paul Fox	4	4	**16**	1. Monitoring the emerging policies.	1. Engaging with GM with a view to being informed of any changes.	1. Awaiting direction from Greater Manchester	CCG Closedown Task & Finish Group Leadership Team Governing Body Audit Committee	None	Significant	3	3	**9**
SO4-007	**Cancer Waits**	Strategic Objective 4: To deliver on the outcomes of the Locality Plan in respect of in hospital - Planned (Getting more help)	IF the system does not achieve the National Performance Target for Cancer due to the continued impact of COVID-19, THEN this will impact on patient outcomes through increased wait times and potentially lead to increased urgent care presentations. Increased wait times have the potential to lead to late diagnosis and inability to treat late-stage cancer.	Nadia Baig	5	4	**20**	1. Rapid Diagnostic Centres in place to support early identification and criteria has been expanded to include a wider range of tumour groups. 2. Rochdale Infirmary is being utilised as a Cancer Hub in an attempt to avoid increased waiting times. 3. All National Cancer screening programmes have recommenced, including risk stratification for Colorectal. The bowel screening age will be lowered to 56 in the next 4 years. 4. Pilot for LGBTQ Cervical screening is live. 5. Cancer Serious Incident Review process in place within Cancer MDT and there will be a focus on the 62 day and 104-day harm reviews that the NCA are highlighting. 6. Endoscopy Hubs in place with additional capacity. 7. System wide Cancer screening engagement meetings lead on increasing Cancer Screening within Primary Care, with a particular focus on hard-to-reach communities following COVID. 8. Bespoke Cancer communications campaign developed with all stakeholders for 21/22. 9. Best Time Pathways in place (Nurse led triage) for Upper GI, Colorectal and Lung. 10. Cancer Champions in place within PCNs	1. Increase FIT Testing across the borough 2. 'Lumps and Bumps' Training to be rolled out to Primary Care 3. Establish 'One Stop Lump Clinic' - April 22 4. Develop Localised Cancer Plan - This will include patients with an LD, in conjunction with LeDeR and the quality team, which will consist of simple to understand information about screening and healthy living, for all residents once rolled out. 5. Cancer Mandate to be developed in Q1	1. Capacity within the system is reduced due to additional IPC measures. No timescales for lifting restrictions. 2. Significant pressures and increased wait times remain in breast, upper G. I, Skin, Head and Neck and Lung due to COVID backlog. 3. COVID backlog is putting pressure on 62-day targets.	**Internal Assurance:** 1. NCA/ Pennine Cancer Improvement Committee 2. HMR CCG Cancer MDT 3. Performance Reports supplied to FPR and Governing Body 4. Planned Care Programme Board 5. Rochdale Cancer Plan delivery governance at LCO **External Assurance:** GM Cancer Alliance (Assurance provided via trusts)	None	Significant	3	3	**12**
SO1-056	**Designated Doctor for Looked after Children (Safeguarding)**	Strategic Objective 1: To be high performing, deliver our statutory duties and use our available	IF a Designated Doctor function is not put in place for Safeguarding, THEN there is a risk that the CCG will not be compliant with statute as per	Alison Kelly (CCG)	5	3	**15**	1. The mitigating actions are that we manage the 'work' aspect of the role via creative methods-reported to GM therefore no gap in provision. 2. Ensure risk is reflected on the register as it is part of our assurance return to GM who dictate we log as risk. 3. An Options Paper regarding Designated	1. Provision and performance across all areas monitored regularly 2. Considering NE sector approach to the function	1. Understanding of implications is currently limited but developing through the GM and locality construct work.	Quality and Safeguarding Committee bi-monthly and reported quarterly to GMHSCP.	None	Significant	3	4	**12**

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		resources innovatively to deliver the best outcomes for our population	Intercollegiate directives.					Doctor and Nurse provision has been prepared and shared with Execs for decision making regarding increased resource. Once final agreement made, posts will be recruited to.								
SO1-045	**Designated Doctor for Looked after Children**	Strategic Objective 1: To be high performing, deliver our statutory duties and use our available resources innovatively to deliver the best outcomes for our population	IF a Designated Doctor function is not put in place for Looked After Children, THEN there is a risk that the CCG will not be compliant with statute as per Intercollegiate directives	Alison Kelly (CCG)	5	3	**15**	1. The mitigating actions are that we manage the 'work' aspect of the role via creative methods-reported to GM therefore no gap in provision. 2. Ensure risk is reflected on the register as it is part of our assurance return to GM who dictate we log as risk. 3. An Options Paper regarding Designated Doctor and Nurse provision has been prepared and shared with Execs for decision making regarding increased resource. Once final agreement made, posts will be recruited to.	1. Provision and performance across all areas monitored regularly 2. Considering NE sector approach to the function	Understanding of implications is currently limited but developing through the GM and locality construct work.	Quality and Safeguarding Committee bi-monthly and reported quarterly to GMHSCP.	None	Significant	3	4	**12**
SO1-052	**Liberty Protection Safeguards and (LPS) Implementation (Healthcare)**	Strategic Objective 1: To be high performing, deliver our statutory duties and use our available resources innovatively to deliver the best outcomes for our population	IF CHC, as Responsible Body, do not adhere to their legal duty to apply Liberty Protection Safeguards (formerly Deprivation of Liberty Safeguards) to patients receiving a Continuing Health Care (CHC) Funded Package of Care in a community setting, THEN there is a risk to patient safety and wellbeing as people may be deprived of their liberty without the authorisation of due legal process.	Alison Kelly (CCG)	3	5	**15**	1. Rochdale Borough Safeguarding Adult Board (RBSAB) 2. Liberty Protection Safeguards (LPS) Working Group 3. Ongoing work with CHC/Adult Care to ensure issue remains a priority 4. Initial scoping of DoLs cases managed by Local Authority & scoping of potential LPS CHC eligible cases. 5. Regular monitoring & assurance provided to Greater Manchester Health & Social Care Partnership (GMHSCP).	1. Review Guidance when guidance is issued to develop a workplan to implement.	A parliamentary Statement was released on 16.07.21 in relation to the Mental Capacity Amendment Act (2019) /Liberty Protection Safeguards (LPS). The original intention was for the LPS to be implemented in October 2020. The statement noted that this was no longer possible and that the aim is for full implementation of the LPS by April 2022 A draft code of practice and regulations will be made available in due course; the statement advises that this will happen well in advance of the target date.	RBSAB, LPS Working Group Governing Body, Audit Committee	None	Significant	3	4	**12**
SO1-070	**Uncertainty of the locality's accountability for performance against the activity plan submission**	Strategic Objective 1: To be high performing, deliver our statutory duties and use our available resources innovatively to deliver the best outcomes for our population	IF the planning activity submission information and assumptions are not available to localities because plans have been aggregated across GM and responsibility for delivering on plans is not clear THEN this will mean there is continued uncertainty as to whether the locality or GM is accountable for performance against the activity plans.	Chris Tyson	4	4	**16**	1. BI leads have requested a lessons learned session with GMHSCP to discuss the planning process and how to ensure it is managed in the future. The first meeting will take place on the 6/5/2022 2. Regular performance updates throughout year 3. Be engaged with the GM planning teams and Assurance teams around performance and planning in 2022/23.	1. Be engaged in future planning groups with GM and Provider Federation Board (PFB) for future planning rounds. 2. Monitoring of performance throughout 2022/23. Raising any performance issues with the system	1. Understand the new assurance process for performance in the ICS and escalation of performance issues for 2022/23 whether through place, locality or PFB	Internal CCG Closedown Group External Provider Federation Board (PFB)	None	Significant	3	4	**12**
SO3-026	**PCN maturity**	Strategic Objective 3: To deliver on the outcomes of the Locality Plan in respect of Neighbourhoods	IF Primary Care Networks (PCNs) do not further develop partnership working between practices and leadership skills among their members,	Sarah Crossley	4	4	**16**	1. Primary Care Mandate priority programmes include PCN Development and PCN Clinical Leadership. 2. RHA / Academy / CCG to develop co-production approach to PCN Development and leadership 3. RHA / Academy and CCG to continue to	1. Development of a system-approach across all primary care providers to the development of PCNs	1. PCNs are independent delivery groups so the CCG does not have direct control over their approach to business planning and development	1. Primary Care Mandate - monthly highlight reporting, 2. PCAT, 3. PCCC, 4. LCO Exec, 5. Locality Construct	None	Significant	3	4	**12**

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		and Primary Care	THEN they will not be able to deliver their contractual (Directed Enhanced Service) requirements - this will impact on their ability to deliver transformational system change within their PCN and with wider health and care partners.					support PCN monthly meetings and business planning 4. Monthly meetings between CCG and PCN Clinical Directors (CDs) 5. Matrix self-assessment								
SO1-062	**Review of deaths of patients with Learning Disabilities and Autism**	Strategic Objective 1: To be high performing, deliver our statutory duties and use our available resources innovatively to deliver the best outcomes for our population	IF we don't adhere to our duty to follow the national service improvement programme, to report and implement learning from the review process THEN we wouldn't address the significant health inequalities experienced by individuals with Learning disabilities and autism and will fail to reduce mortality rates for these individuals	Alison Kelly (CCG)	5	5	**25**	1. LeDeR steering group in place to review any finding 2. Individual in post to review all deaths and provide recommendations 3. Attending GM LeDeR Operational group 4. GM ICS restructure development working group attendance (name TBC) 5. Health check reviews take place annual with GPs - reviews of the process continues via task and finish group. 6. Quarterly Learning Disability newsletter for the system to raise awareness of the inequalities and support available. 7. LD healthy weight working group established under Health Weight Steering Group 8. LD is one of priority areas identified in Cancer Engagement meeting	1. GM ICS LeDeR development work including establishment of GM Quality assurance group	1. National Policy Changes 2. ICS restructure of the review process 3.Understanding of implications is currently limited but developing through the GM and locality construct work	1. LeDeR Steering Group 2. GM LeDeR Operational Group 3. Mortality Review group 4. Leading Disability Partnership Board 5. Rochdale Borough Safeguarding Adults Board 6. Local Governance panels and the ICS will be held accountable by NHS England & NHS Improvement for achieving the system objectives of service improvement.	None	Significant	3	4	**12**
SO3-035	**COVID 19 mass vaccinations - vaccine delivery**	Strategic Objective 3: To deliver on the outcomes of the Locality Plan in respect of Neighbourhoods and Primary Care	IF GP practices and pharmacies choose to not sign up to deliver the COVID-19 vaccine programme delivery THEN this will inhibit the delivery of the overall COVID-19 vaccination programme.	Kuiama Thompson/ Sarah Crossley	4	4	**16**	1. Weekly clinical leads meeting in place to discuss challenges and issues 2. Developed relationships with other pharmacy providers to be able to deliver pop up clinics if required. 3. Working closely with GM to determine other models of delivery if required. 4. Relationships developed with the hospital hub as alternative delivery if required.	None	1. Future national programme delivery. 2. Contract directly between NHSE/ PCNs 3. No national contract in place post 1st April 2022.	1. HMR Covid Vaccination Operational Group, 2. Covid Vaccination Oversight Group 3. Covid Vaccination Programme Board 3. Gold, 4. Clinical Leads meeting weekly, 5. PCN colleagues.	None	Significant	3	3	**9**
SO1-048	**Continuity of Quality, Safety and Safeguarding after CCG closedown in July 2022**	Strategic Objective 1: To be high performing, deliver our statutory duties and use our available resources innovatively to deliver the best outcomes for our population	IF Quality, Safety and Safeguarding functions are delivered across the Integrated Care System (ICS) footprint following the closure of the CCG, THEN there will be a reduction in placed based oversight and assurance at a local level.	Alison Kelly (CCG)	4	4	**16**	1. Chief Nurse, Designated Nurse/ Professional and Quality Lead ensuring potential risk is recognised and mitigated against.	1. Provision and performance across all areas monitored regularly 2. Progressing with locality construct integration work. Statutory function maintained currently. 3. Plans updated as GM ICS work develops	Understanding of implications is currently limited but developing through the GM and locality construct work.	Quality and Safeguarding Committee bi-monthly and reported quarterly to GMHSCP.	None	Significant	3	4	**12**
SO1-058	**Inability to financially plan beyond 22/23**	Strategic Objective 1: To be high performing, deliver our statutory duties and use our available resources innovatively to deliver the best outcomes for our population	IF there continues to be uncertainty regarding the financial decision-making responsibilities at locality and GM level. THEN we will not have the level of flexibility needed to reallocate funding, which could impact planning of service provision in the locality.	Jonathan Evans /System DOFS	4	5	**20**	1. Discussion paper on Financial Flows produced 2. Key assumptions agreed 3. Key principles to support financial flows and financial management agreed 4. Draft financial flow proposals developed	1. Review of all contracts to ensure value for money and exit clauses. 2. Work closely with providers and LCO to fully understand activity, costs, and future capacity plans 3. The GM Provider Directors of Finance and CCG CFOs have worked collaboratively to model the GM system financial models and develop mitigation plans and areas of GM efficiencies to manage within a system control total for the period 2022/23. This will be monitored	Finance workstream is highly dependent on other workstreams determining the overall approach to decision making and spatial approach as well as any national guidance	1. CFO joins fortnightly regional meetings and weekly GM CFOs where this is regularly discussed. 2. Regular updates to FPR, ICB , Audit Committee and Governing Body. 3. Reporting through LCO Board and System Board 4. NHSE	None	Significant	2	4	**8**

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									through the GM CFO meeting in year. 4. Work to continue across GM including: a. Financial flows b. Financial regime within GMICS c. National Financial Framework							
SO4-011	**Infection Prevention Control (IPC) impact on capacity.**	Strategic Objective 4: To deliver on the outcomes of the Locality Plan in respect of in hospital - Planned (Getting more help)	IF the guidance for Infection Prevention Control (IPC) and/or the delivery of elective procedures is revised. THEN this will impact on the Trust's ability to deliver elective activity and will impact our ability to meet the National Target set within the Planning Guidance.	Nadia Baig/ Keeley Gibbons	4	4	**16**	1. Monitor progress against targets set nationally to inform action plan	1. Monitor impact of any changes to IPC and Social Distancing Guidance	Infection Prevention and Control measures are in place that need to be adhered to.	**Internal Assurance:** 1. Planned Care Programme Board **External Assurance:** Not applicable	None	Significant	3	3	**9**
SO1-064	**Implementation and embedding of learning from reviews of deaths of patients with learning disabilities and autism**	Strategic Objective 1: To be high performing, deliver our statutory duties and use our available resources innovatively to deliver the best outcomes for our population	IF there is not a local coordinator who reviews and implements/ embeds the learning from the review process THEN health inequalities for those with learning disabilities will not be addressed.	Alison Kelly (CCG)	5	5	**25**	1. Currently assigned to the designated safeguarding lead for adults as part of their wider role 2. Attending GM LeDeR Operational group 3. Attending GM LeDeR Project Group 4. Health check reviews take place annual with GPs - reviews of the process continues via task and finish group. 5. Quarterly Learning Disability newsletter for the system to raise awareness of local learning and action from learning	1. Identify additional individual to support or who would be better linked into the system	1. This work will be sitting under the GM ICS 2. GM Learning disability and autism programme board 3. Understanding of implications is currently limited but developing through the GM and locality construct work	1. LeDeR Steering Group 2. GM LeDeR Operational Group 3. Mortality Review group 4. Leading Disability Partnership Board 5. Rochdale Borough Safeguarding Adults Board 6. Local Governance panels and the ICS will be held accountable by NHS England & NHS Improvement for achieving the system objectives of service improvement.	None	Significant	3	3	**9**
SO1-066	**CCG Closedown - Electronic Management**	Strategic Objective 1: To be high performing, deliver our statutory duties and use our available resources innovatively to deliver the best outcomes for our population	IF there is not a network or shared repository for the storage of records, including an electronic records management file structure and adequate file plans in place for digital repositories. THEN this will lead to loss of assets or inability to access documents.	Chris Upton	4	4	**16**	1. Current structures are in place within the CCG. 2. Gain assurance from GMSS in the event of no consolidation of the locality structure e.g., Teams, local drives.	1. Head IT and assurance is sat of the GM Executive Board.	1. Awaiting direction from Greater Manchester	CCG Closedown Task & Finish Group Leadership Team Governing Body Audit Committee	None	Significant	3	3	**9**
SO6-053	**Limited data submitted by provider in relation to child development outcomes (ASQ data and 0-5 mandated contacts)**	Strategic Objective 6: To deliver on the outcomes of the Locality Plan in respect of Children, young people and families	The ASQ* data for Q2 21/22 was unavailable to submit due to a system change in in NCA (*data and 0-5 mandated contacts) IF this continues THEN we will be: a) unable to comply with national reporting requirements b) unable to strategically assess the impact of the pandemic and deploy resources to respond to need as	Lianne Davies / Kuiama Thompson (Adam Sutcliffe)/ Zeph Curwen	4	4	**16**	Initial indication provided by NCA that the issues with the system will be rectified by June 2022. Local colleagues are working together to expedite these timescales.	NCA have agreed to further escalate within the organisation to resolve		Recovery and Quality Group (members NCA and commissioners)	None	Significant	2	4	**8**

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			appropriate. *population measure of child development													
SO6-007.c	**Escalating waiting times for autism assessment (Healthy Young Minds – children aged over 5 years)**	Strategic Objective 6: To deliver on the outcomes of the Locality Plan in respect of Children, young people and families	IF the demand for Autism Diagnostic Observation Schedule (ADOS) assessments remain high for children aged over 5. THEN this will delay timely diagnosis/support and is likely to negatively impact their education, health and life chances.	Charlotte Mitchell/Nadia Baig	5	4	20	1. Informal recovery action plan agreed with provider. 2. Escalated to Greater Manchester Integrated Care System (GM ICS). 3. Discussed at strategic level. 4. Assessment has now recommenced with the use of masks. 5. Staff working weekends to cover additional clinics. 6. Pennine Care are now undertaking structured observations to address waiting list. 7. Funding secured from GM to develop a new MDT autism team and plans are in mobilisation stage.	1. Working group has been established to design a Rochdale multi-disciplinary autism pathway and funding has been secured none recurrently from GM.	1. No trajectory has been included within the action plan to address how and when will then backlog will be recovered.	Children with Disabilities Partnership Risk, Finance and Performance Leadership SCCMB, GM Community Camhs Board, NHS England, CQC, Ofsted	None	Significant	3	3	9
SO6-006	**Increase in Safeguarding Concerns post lockdown**	Strategic Objective 1: To be high performing, deliver our statutory duties and use our available resources innovatively to deliver the best outcomes for our population	If there is increased demand in Children's Social Care, then this will impact upon statutory duties of universal health services (School Nursing Team) to prioritise and respond to the needs of children where there are safeguarding concerns/ or cared for children. This will place further pressures on Children's Health Services. Surge data provided from children's social care evidenced significant increase in referrals and acuity of need. There will be an increased reliance on health professionals to initiate and hold children at Early Help level were identified and to contribute to safeguarding plans.	Adam Sutcliffe	5	4	20	1. Additional investment in the school nursing service has been agreed between Public Health and NCA. This will enable a pilot project to be implemented that involves the creation of a dedicated safeguarding staff team within school nursing and increasing capacity to deliver the public health interventions, the Healthy Child Programme and Early Help. Implementation is currently underway. Regular implementation meetings in place between NCA, Public Health and HMR CCG Safeguarding.	1. Continue with the full implementation of the new staffing model in school nursing, delayed but still ongoing due to the Nursing Service deliver the 12–15-year-old Covid Vaccination Programme during the first school term and post-Christmas term. 2. 3.5 out of 5 posts have candidates appointed. Recruitment of the additional staff to support the model is ongoing. 3. Work is underway to jointly define the outcomes we will monitor to assess the impact of this way of working. 4. Determine utilisation of additional spend during the next mobilisation meeting. 5. Develop plan for post proof of concept period for sustaining model.	None	1. CYPP 2. Oversight from FSM Board	None	Significant	2	3	6
SO3-022	**COVID-19 mass vaccinations - vaccine inequality**	Strategic Objective 3: To deliver on the outcomes of the Locality Plan in respect of Neighbourhoods and Primary Care	IF vaccine uptake in some vulnerable population groups (including BAME communities and areas of deprivation) remains lower than local and national averages, THEN vulnerable members of the community will be at greater risk of serious illness and hospitalisation from COVID-19 and flu.	Sarah Crossley	5	4	20	1. The recent Booster programme in addition to increasing 1st and 2nd doses continues. 2. A whole-system vaccine inequalities group was established and an agreed group review and respond to the latest data on vaccine uptake and inequalities (these are measured at practice, neighbourhood and ethnicity or group level). 3. Reporting and assurance is via the Vaccine Oversight Group and Programme Board. 4. A number of targeted pop-up vaccine clinics and offers of vaccine in areas of low vaccine uptake continue to take place. 5. Neighbourhood work takes place on a	Ongoing work to identify and tackle inequalities in coverage from existing and current focus on the booster programme to mitigate the risks of any reduction in protection and new variants.	1.Patient choice and vaccine hesitancy. 2.The infection rate of Omicron meaning significant numbers of the population are currently ineligible for the vaccine or booster for a further 28 days.	1. HMR Covid Vaccination Working Group, 2. Gold, 3. Silver 4. HMR Vaccine Inequalities Groups	None	Significant	3	3	9

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								regular basis and Health Champions and other community facing workers and volunteers are supporting vaccine uptake conversations with targeted groups - they are speaking to residents in targeted communities to encourage uptake.								
SO3-006	**Primary Care Workforce**	Strategic Objective 3: To deliver on the outcomes of the Locality Plan in respect of Neighbourhoods and Primary Care	IF primary care demand continues to exceed capacity because of the combined impacts of a) COVID-19 on staff working patterns and operating models, b) recovering the backlog of care and c) embedding sustainable new ways of working, THEN this will increase pressure on other parts of the health and care system.	Sarah Crossley	3	5	**15**	1. Primary Care Mandate has a priority programme dedicated to primary care workforce resilience and retention with the Academy and CCG jointly leading this programme. 2. The HMR Primary Care Academy continues to support sustainability of the workforce through its programme of training and development. 3 Recruitment is underway for Additional Roles in primary care as part of the national PCN Additional Roles Reimbursement Scheme (ARRS). System work getting underway with all primary and community partners to look at opportunities to work collaboratively in the recruitment and retention of additional roles. 4. the HMR Primary Care Academy is implementing a programme of GP resilience with a focus on leadership development in middle-years GPs. 5. Fully embed workforce returns in general practice (HEE returns and Pulse Check processes) 6. The Academy has led on the development of a primary care workforce (Lantum) bank which can provide both clinical and admin staff to support practices in need 7. Robust testing practice in place and COVID-19 vaccine programme in place, should help reduce the impact on workforce due to COVID-19 infection. 8. Winter Access Funding is being rolled out in general practice to provide additional capacity and greater resilience, until March 2022. This funding is also being used to commission Primary Care Hubs at Whitehall St and the Phoenix Centre.	1. Regular meetings with GMHSCP. 2. Increase of retention and recruitment activities through GP retention monies. 3. Keeping abreast of new and innovative roles which will complement the GP role. 4. Robust data collection and monitoring of number of GPs, planned retirement and development of action plans to support recruitment and retention and introduce new roles. 5. Annual targets and payment made accordingly. 6. ARRS roles are difficult to recruit and embed and require a lot of PCN development time. There is insufficient funding for ARRS role management and supervision costs in the ARRS budget.	1. National and GM shortage of health care professional roles.	1. Primary Care Workforce Mandate Delivery Group, 2. Quarterly ARRS submissions, 3. LCO Exec, 4. PCAT, 5. PCCC, 6. Regular assurance meetings between LCO, CCG and GM Workforce Group.	None	Significant	3	3	**9**
SO6-007.e	**Surges in crisis demand for Acute Children's Mental Health Services**	Strategic Objective 6: To deliver on the outcomes of the Locality Plan in respect of Children, young people and families	If there continues to be an increase in the level of crisis presentations for Acute Children's Mental Health Services, THEN there will continue to be an increase in waiting times for children and young people to access the core CAMHS community pathway pathways because the Children's Adolescent Mental Health Service (CAMHS) workforce will have to prioritise 7-day follow ups.	Charlotte Mitchell/ Nadia Baig	4	4	**16**	Regular meetings with Pennine Care. Regular discussion at SCCMB. Investment into crisis care pathways via GM. Design of new models of care to support cared for children in crisis. Development of new multi-agency MH pathway where Children's Social Care must follow an agreed process before escalation to commissioners.	Escalate to GM the need to develop an OPEL Dashboard to monitor system flow and pressures. Discussions with provider around weekly pressures meetings with mental health. Development of local MALM protocol. Socialising with Children's services SMT. Development of dynamic support process for Crisis MH.	None	SCCMB GM Crisis Care Board	None	Significant	3	3	**9**

					Inherent Risk								Residual		
Corporate Risk Register Ref	Risk Title	Strategic Objective	Risk Description	Risk Owner	Likelihood	Impact	Score	Mitigating Actions	Actions to further mitigate	Gaps in Controls	Assurance	Gaps in Assurance	Assurance Level	Likelihood	Impact	Score
SO2-008	**Exacerbated health inequalities**	Strategic Objective 2: To deliver on the outcomes of the Locality Plan in respect of P&A (Prevention and Self Care)	IF we do not have adequate plans in place to address increasing health inequalities due to the impact of Covid-19 (specifically unfair and unjust inequality), then the outcomes for our residents will be negatively impacted	Kuiama Thompson/ Anthony Threlfall	5	5	25	1. A full programme of work is underway in regards to the management of waiting lists through the LCO programmes in order to address inequalities in access to health and care services. 2. LCO Business Plan developed which details our system plans for reducing inequality 3. Cancer and CVD programme being established 4. Prevention Strategy developed	Continue working to address Inequalities in outcomes especially by ensuring equitable access to services	Cannot control the long term sequential impact of the pandemic. E.g. we know that children have been impacted long term in terms of their development. However we do not know the long term effect of this. Also the long term impact of long covid.	1.People and Place partnership 2.LCO SMT 3.LCO Exec 4.LCO Board 5. System Board	None	Significant	5	4	20
SO4-010	**System impact of increased waiting times for treatments**	Strategic Objective 4: To deliver on the outcomes of the Locality Plan in respect of In hospital - Planned (Getting more help)	IF we fail to reduce waiting times across the system THEN patients are at risk of both harm or poorer outcomes and increased cost to the system due to increased acuity at the time of treatment.	Steve Taylor	5	4	20	1. Waiting list recovery programme established within year 2 of LCO mandate. 2. Waiting list is being monitored and reported through the performance report 3. Working with Independent Sector providers and the trust to reduce waiting lists using the Independent Sector Capacity Framework for transferring patients 5. HMR continues to work with the GM Elective Reform Recovery and Restoration Operations Group on identified Waiting List initiatives 6. Quality & Safeguarding consideration for all patients. Harm reviews to be undertaken for all patients and prioritised accordingly. 7. Engaging with the General Public - GM have established a While You Wait website, which provides information on how to manage conditions and wellbeing whilst waiting for treatment. 8. Engagement with Individuals - GP practices now have information to relay to patient about average length of wait which they communicate to patients directly.	1. Working with the providers to support appropriate prioritisation of waiting list. 2. Awaiting national guidance on patient choice. 3. Further work on communications required 4. Development of Equality Audit to support review of the waiting list (linking with Public Health) 5. Establish ' GM My Planned Care' Programme **6. Engagement with general Public -** Developing stronger links with community facing organisations and VCSE sector to disseminate messaging. **7. Engagement with individuals -** Working with providers to confirm arrangements for contacting individuals on the waiting list (in line with planning guidance). 8. Developing the Prehabilitation Offer to inform people how to prepare for and be fit for surgery. 9.Implementation of PIFU and Advice and Guidance.	Activity requirements in relation to the operating plan are being met but this is not enough activity to reduce the waiting times. Detailed plans to be developed for all specialties to support system planning . No cross-system data on community waits	**Internal Assurance:** 1. Reporting through system board and CCG assurance - FPR, ICB and Governing Body. 2. Reporting through LCO assurance - LCO Planned Care Programme Board, LCO Exec and LCO Board **External Assurance:** 1. GM Elective Care Recovery and Reform Programme hosted by Stockport FT	None	Significant	4	4	16
SO4-187	**Impact of increased waiting times for treatment (all age)**	Strategic Objective 4: To deliver on the outcomes of the Locality Plan in respect of In hospital - Planned (Getting more help)	IF people continue to wait beyond 52-weeks for treatment. THEN patients are at risk of both harm or poorer outcomes and increased cost to the system due to increased acuity at the time of treatment.	Nadia Baig	5	4	20	1. Waiting list recovery programme established within year 2 of LCO mandate. 2. Waiting list is being monitored and reported through the performance report 3. Working with Independent Sector providers and the trust to reduce waiting lists using the Independent Sector Capacity Framework for transferring patients 5. HMR continues to work with the GM Elective Reform Recovery and Restoration Operations Group on identified Waiting List initiatives 6. Quality & Safeguarding consideration for all patients. Harm reviews to be undertaken for all patients and prioritised accordingly. 7. Engaging with the General Public - GM have established a While You Wait website, which provides information on how to manage conditions and wellbeing whilst waiting for treatment. 8. Engagement with Individuals - GP practices now have information to relay to patient about average length of wait which they communicate to patients directly. 9. Oldham developed 104 week wait trajectory expected to be cleared by July 22.	1. Working with the providers to support appropriate prioritisation of waiting list. 2. Awaiting national guidance on patient choice. 3. Further work on communications required 4. Development of Equality Audit to support review of the waiting list (linking with Public Health) 5. Establish ' GM My Planned Care' Programme **6. Engagement with general Public -** Developing stronger links with community facing organisations and VCSE sector to disseminate messaging. **7. Engagement with individuals -** Working with providers to confirm arrangements for contacting individuals on the waiting list (in line with planning guidance). 8. Developing the Prehabilitation Offer to inform people how to prepare for and be fit for surgery.	Activity requirements in relation to the operating plan are being met but this is not enough activity to reduce the waiting times. Detailed plans to be developed for all specialties to support system planning . No cross-system data on community waits	**Internal Assurance:** 1. Reporting through system board and CCG assurance - FPR, ICB and Governing Body. 2. Reporting through LCO assurance - LCO Planned Care Programme Board, LCO Exec and LCO Board **External Assurance:** 1. GM Elective Care Recovery and Reform Programme hosted by Stockport FT	None	Significant	4	4	16
SO4-009	**Diagnostic Waits**	Strategic Objective 4: To deliver on the outcomes of the Locality Plan in respect of In hospital - Planned (Getting more help)	IF diagnostics waits continue to increase THEN this will impact on patient outcomes, as patients become more unwell whilst waiting and this could lead to a further delay in treatment.	Nadia Baig	5	4	20	1.Cancer Best Time Pathways in place (Nurse-led triage) for Upper Gastrointestinal (GI), Colorectal and Lung. 2.HMR CCG continues to work with the GM Elective Reform 3.Implemented 'Straight to CT' for abnormal Lung X-Ray 4.GP Direct Access Diagnostics (DAD) for NOUS, Head and Neck MRI and Audiology now live - Community Based Service releasing capacity and secondary care 5.Phase One While You Wait Website - now live 6.Implemented Blood Pressure Monitors at Home Scheme	1. Development of While You Wait Programme (System Wide) 2. HMR to engage with GM Echo elective wait programme. 3. HMR to work with local diagnostic (Echo) provider to develop a waiting list initiative 4. Implement 'Straight to CT' for abnormal Lung X-Ray 5. HMR CCG to work with NCA on establishment of Community Diagnostic Hub (in Royton) 6. Continuing to pay premium to Tameside and Glossop to support skin 2 week wait diagnosis	1. Performance Reporting with the trust has been stood down. However, we continue to monitor locally with our BI Partners and independent sector. 2. Cancer patients are currently being prioritised over RTT patients on the Radiology Waiting List	**Internal Assurance:** 1. Planned Care Programme Board 2.Monthly MDT meetings to discuss specific areas of under-performance 3. Performance Reports supplied to FPR and Governing Body 4. Routinely discussed at Governing Body **External Assurance:** 5. GM Elective Reform Recovery and Restoration Operations Group	None	Significant	5	3	15

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SO5-004	**Constitutional Performance for A&E - specifically in relation to 12 hour waits**	Strategic Objective 5: To deliver on the outcomes of the Locality Plan in respect of In Hospital – Urgent Care (Getting more help)	IF non-compliance with the NHS Constitution performance measures (a) 4 Hour Waiting Time b) 12-Hour Trolley Waits c) Ambulance Response Times for Cat 3 Calls d) Hospital Handover Delays > 30 mins 12-hour trolley waits in A&E) continues THEN there is a risk that patient outcomes may be impacted.	Nadia Baig/Shaju Ahmed	5	4	15	1.Same Day Emergency Care (SDEC) pathways into Rochdale Infirmary in place for HMR patients. During surge support is provided for neighbouring Royal Oldham Hospital (ROH) and Fairfield General Hospital (FGH), with option to support North East Sector (NES) patients during time of surges. 2.Communication and dialogue with the care home sector in place with active promotion of 2hr community response (Rapid Response and Rochdale SDEC) and 24/7 Single Point of Access now operating for Rapid Response for care homes. The Enhanced Care Homes Direct Enhanced Service (DES) also supporting with weekly check-in via Primary Care Networks (PCNs). 3.Processes and teams in place to improve discharges via Home in a Day, Discharge to Assess, & patient transport services 4.Greater Manchester Clinical Assessment Service (GMCAS) pulling suitable 999 /111 patients from the stack reducing demands on North West Ambulance Service (NWAS) and Accident & Emergency (A&E) departments. 5.Pre-Emergency Department (Pre ED) streaming in place at both ROH and FGH redirecting lower acuity HMR patients to suitable primary, community services or Rochdale Urgent Treatment Centre (UTC) 6.PCN Hub at Whitehall Street and Phoenix offering additional primary	1. Performance across all Constitution areas monitored regularly via Governing Body & ICB. 2. Further analysis to be provided regularly to various internal committees and urgent care MDTs. 3. Planning Guidance for 2022-23 sets out the priority to eliminate 12 hour waits in EDs. Currently reviewing if any further actions required. 4. Develop plans to increase usage of virtual wards via SDEC as well as opportunities to increase usage of Rochdale SDEC rather than patients conveying at ROH and FGH SDEC services. 5. Development of a system wide admission avoidance scheme to support care homes. 6. Planning guidance sets out requirements to improve against all constitutional performance measures. This will be a focus at GM level for 2022/23. 7. Royal Oldham and Fairfield remedial action	HMR patients attending Oldham and Bury. Improvement plans at GM level for ambulance performance. Need more oversight.	LCO UEC Programme Board GM Discharge meetings Governing Body ICB, MDT	None	Significant	5	3	15
SO1-062	**Review of deaths of patients with Learning Disabilities and Autism**	Strategic Objective 1: To be high performing, deliver our statutory duties and use our available resources innovatively to deliver the best outcomes for our population	IF we don't adhere to our duty to follow the national service improvement programme, to report and implement learning from the review process THEN we wouldn't address the significant health inequalities experienced by individuals with Learning disabilities and autism and will fail to reduce mortality rates for these individuals	Alison Kelly (CCG)	5	5	25	1. LeDeR steering group in place to review any finding 2. Individual in post to review all deaths and provide recommendations 3. Attending GM LeDeR Operational group 4. GM ICS restructure development working group attendance (name TBC) 5. Health check reviews take place annual with GPs - reviews of the process continues via task and finish group. 6. Quarterly Learning Disability newsletter for the system to raise awareness of the inequalities and support available. 7. LD healthy weight working group established under Health Weight Steering Group 8. LD is one of priority areas identified in Cancer Engagement meeting	1. GM ICS LeDeR development work including establishment of GM Quality assurance group	1. National Policy Changes 2. ICS restructure of the review process 3.Understanding of implications is currently limited but developing through the GM and locality construct work	1. LeDeR Steering Group 2. GM LeDeR Operational Group 3. Mortality Review group 4. Leading Disability Partnership Board 5. Rochdale Borough Safeguarding Adults Board 6. Local Governance panels and the ICS will be held accountable by NHS England & NHS Improvement for achieving the system objectives of service improvement.	None	Significant	3	4	12
SO1-046	**Establishment of GM ICS and Rochdale Locality Construct**	Strategic Objective 1: To be high performing, deliver our statutory duties and use our available resources innovatively to deliver the best outcomes for our population	IF we do not establish clear lines of accountability and responsibility within our locality operating model that ensures adherence to statutory duties, supports enabling functions and that aligns with GM ICS THEN we will be unable to effectively deliver the outcomes described in the locality plan.	Claire Richardson/ Steve Taylor	4	4	16	1. The development of the locality construct is underway with clear links and reporting into the HMR Integrated Commissioning Board with full participation from across the health and care system. 2. The locality construct work is being undertaken with a full knowledge of plans at a Greater Manchester level and key individuals collaborating on the GM proposals are also informing our local work. 3. Finance, Performance and Risk, Quality and Safety and Workforce subcommittees are now in place and reporting to LCO Board and Shadow System Board. 4.Rochdale System Operating Model now agreed through LCO Board, Shadow System Board and ratified through the Integrated Commissioning Board 10. LCO Business Plan established to ensure focus on delivery across the system	1. Continued communication and ensuring the Rochdale locality position is reflected in what is proposed at GM - ensuring local services stay locally commissioned 2. Partnership agreements as set out in the Operating Model to be developed 3. LCO Business plan refresh to take account of NHS planning guidance 4. Agree reporting arrangements from sub committees to LCO Board 5. Further development work for Operating Model to include GM delegations (when known), staffing arrangements and financial arrangements	1. Spatial framework is not yet published - this will inform further planning. Current planning based on assumptions 2. Process for managing conflicts of interest needs to be developed	Reporting through: 1.ICB/ System Board 2. LCO Board 3. CCG Governing Body	None	Significant	3	4	12
SO4-007	**Cancer Waits**	Strategic Objective 4: To deliver on the outcomes of the Locality Plan in respect of In hospital - Planned (Getting more help)	IF the system does not achieve the National Performance Target for Cancer due to the continued impact of COVID-19, THEN this will impact on patient outcomes through increased wait times and potentially lead to increased urgent care presentations. Increased wait times have the potential to lead to late diagnosis and inability to treat late stage cancer.	Nadia Baig	4	4	16	1. Rapid Diagnostic Centres in place to support early identification and criteria has been expanded to include a wider range of tumour groups. 2. Rochdale Infirmary is being utilised as a Cancer Hub in an attempt to avoid increased waiting times. 3. All National Cancer screening programmes have recommenced, including risk stratification for Colorectal. The bowel screening age will be lowered to 56 in the next 4 years. 4. Pilot for LGBTQ Cervical screening is live. 5. Cancer Serious Incident Review process in place within Cancer MDT and there will be a focus on the 62 day and 104 day harm reviews that the NCA are highlighting. 6. Endoscopy Hubs in place with additional capacity. 7. System wide Cancer screening engagement meetings lead on increasing Cancer Screening within Primary Care, with a particular focus on hard to reach communities following COVID. 8. Bespoke Cancer communications campaign developed with all stakeholders for 21/22. 9. Best Time Pathways in place (Nurse led triage) for Upper GI, Colorectal and Lung. 10. Cancer Champions in place within PCNs 11. Straight to CT Lung X Ray and pilot Chest X Ray.	1. Increase FIT Testing across the borough 2. 'Lumps and Bumps' Training to be rolled out to Primary Care 3. Establish 'One Stop Lump Clinic' - April 22 4. Develop Localised Cancer Plan - This will include patients with an LD, in conjunction with LeDeR and the quality team, which will consist of simple to understand information about screening and healthy living, for all residents once rolled out. 5. Cancer Mandate to be developed in Q1 6. In Q2 a CRUK cancer van will be Rochdale for 3 days. Work will take place with Answer Cancer to put on roadshows in Middleton and Heywood in the summer, to improve screening rates and encourage patients to seek help.	1. Capacity within the system is reduced due to additional IPC measures. No timescales for lifting restrictions. 2. Significant pressures and increased wait times remain in breast, upper G. I, Skin, Head and Neck and Lung due to COVID backlog. 3. COVID backlog is putting pressure on 62 day targets.	**Internal Assurance:** 1. NCA/ Pennine Cancer Improvement Committee 2. HMR CCG Cancer MDT 3. Performance Reports supplied to FPR and Governing Body 4. Planned Care Programme Board 5. Rochdale Cancer Plan delivery governance at LCO **External Assurance:** GM Cancer Alliance (Assurance provided via trusts)	None	Significant	3	4	12

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SO6-054	**Children's Waiting Times for Speech Language Therapy (SLT)**	Strategic Objective 6: To deliver on the outcomes of the Locality Plan in respect of Children, young people and families	IF we fail to reduce SLT waiting times and provide support to those children waiting THEN this could negatively impact children's long term health inequalities and life outcomes.	Steve Kay/ Charlotte Mitchell	4	4	16	1. Funding for waiting lists backfill 2021 £250k (recruitment challenges) 2. Monthly quality recovery challenge and support meetings. 3. 2022/23 agreed skill mix funding to increase admin capacity, recruit training posts and develop whilst you wait initiatives to support families. 4. Commission of IMPOWER to review and re-design integrated therapeutic pathways for OT and SLT.	Define the current position and specific system children's plans	None	**Internal Assurance:** 1. Reporting through system board and CCG assurance - FPR, ICB and Governing Body. 2. Reporting through LCO assurance - LCO Planned Care Programme Board, LCO Exec and LCO Board **External Assurance:** 1. GM Elective Care Recovery and Reform Programme hosted by Stockport FT	None	Significant	4	3	12
SO1-048	**Continuity of Quality, Safety and Safeguarding after CCG closedown in July 2022**	Strategic Objective 1: To be high performing, deliver our statutory duties and use our available resources innovatively to deliver the best outcomes for our population	IF Quality, Safety and Safeguarding functions are delivered across the Integrated Care System (ICS) footprint following the closure of the CCG, THEN there will be a reduction in placed based oversight and assurance at a local level.	Alison Kelly (CCG)	4	4	16	1. Chief Nurse, Designated Nurse/ Professional and Quality Lead ensuring potential risk is recognised and mitigated against.	1. Provision and performance across all areas monitored regularly 2. Progressing with locality construct integration work. Statutory function maintained currently. 3. Plans updated as GM ICS work develops	Understanding of implications is currently limited but developing through the GM and locality construct work.	Quality and Safeguarding Committee bi-monthly and reported quarterly to GMHSCP.	None	Significant	3	4	12
SO3-026	**PCN maturity**	Strategic Objective 3: To deliver on the outcomes of the Locality Plan in respect of Neighbourhoods and Primary Care	IF Primary Care Networks (PCNs) do not further develop partnership working between practices and leadership skills among their members, THEN they will not be able to deliver their contractual (Directed Enhanced Service) requirements - this will impact on their ability to deliver transformational system change within their PCN and with wider health and care partners.	Sarah Crossley	4	4	16	1. Primary Care Mandate priority programmes include PCN Development and PCN Clinical Leadership. 2. RHA / Academy / CCG to develop co-production approach to PCN Development and leadership 3. RHA / Academy and CCG to continue to support PCN monthly meetings and business planning 4. Monthly meetings between CCG and PCN Clinical Directors (CDs) 5. Matrix self assessment	1. Development of a system-approach across all primary care providers to the development of PCNs	1. PCNs are independent delivery groups so the CCG does not have direct control over their approach to business planning and development	1. Primary Care Mandate - monthly highlight reporting, 2. PCAT, 3. PCCC, 4. LCO Exec, 5. Locality Construct	None	Significant	3	4	12
SO1-070	**Uncertainty of the locality's accountability for performance against the activity plan submission**	Strategic Objective 1: To be high performing, deliver our statutory duties and use our available resources innovatively to deliver the best outcomes for our population	IF the planning activity submission information and assumptions are not available to localities because plans have been aggregated across GM and responsibility for delivering on plans is not clear THEN this will mean there is continued uncertainty as to whether the locality or GM is accountable for performance against the activity plans.	Chris Tyson	4	4	16	1. BI leads have requested a lessons learned session with GMHSCP to discuss the planning process and how to ensure it is managed in the future. The first meeting will take place on the 6/5/2022 2. Regular performance updates throughout year 3. Be engaged with the GM planning teams and Assurance teams around performance and planning in 2022/23.	2. Escalated Breast and Skin to FPR Committee to seek further support	1. Understand the new assurance process for performance in the ICS and escalation of performance issues for 2022/23 whether through place, locality or PFB	**Internal** CCG Closedown Group **External** Provider Federation Board (PFB)	None	Significant	3	4	12
SO1-056	**Designated Doctor for Looked after Children (Safeguarding)**	Strategic Objective 1: To be high performing, deliver our statutory duties and use our available resources innovatively to deliver the best outcomes for our population	IF a Designated Doctor function is not put in place for Safeguarding, THEN there is a risk that the CCG will not be compliant with statute as per Intercollegiate directives.	Alison Kelly (CCG)	5	3	15	1. The mitigating actions are that we manage the 'work' aspect of the role via creative methods-reported to GM therefore no gap in provision. 2. Ensure risk is reflected on the register as it is part of our assurance return to GM who dictate we log as risk. 3. An Options Paper regarding Designated Doctor and Nurse provision has been approved by Execs for increased resource. Job descriptions and recruitment in progress.	1. Provision and performance across all areas monitored regularly 2. Considering NE sector approach to the function	1. Understanding of implications is currently limited but developing through the GM and locality construct work.	Quality and Safeguarding Committee bi-monthly and reported quarterly to GMHSCP.	None	Significant	3	4	12

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SO1-045	**Designated Doctor for Looked after Children**	Strategic Objective 1: To be high performing, deliver our statutory duties and use our available resources innovatively to deliver the best outcomes for our population	IF a Designated Doctor function is not put in place for Looked After Children, THEN there is a risk that the CCG will not be compliant with statute as per Intercollegiate directives	Alison Kelly (CCG)	5	3	15	1. The mitigating actions are that we manage the 'work' aspect of the role via creative methods-reported to GM therefore no gap in provision. 2. Ensure risk is reflected on the register as it is part of our assurance return to GM who dictate we log as risk. 3. An Options Paper regarding Designated Doctor and Nurse provision has been approved by Execs for increased resource. Job descriptions and recruitment in progress.	1. Provision and performance across all areas monitored regularly 2. Considering NE sector approach to the function	Understanding of implications is currently limited but developing through the GM and locality construct work.	Quality and Safeguarding Committee bi-monthly and reported quarterly to GMHSCP.	None	Significant	3	4	12
SO1-052	**Liberty Protection Safeguards and (LPS) Implementation (Healthcare)**	Strategic Objective 1: To be high performing, deliver our statutory duties and use our available resources innovatively to deliver the best outcomes for our population	IF CHC, as Responsible Body, do not adhere to their legal duty to apply Liberty Protection Safeguards (formerly Deprivation of Liberty Safeguards) to patients receiving a Continuing Health Care (CHC) Funded Package of Care in a community setting, THEN there is a risk to patient safety and wellbeing as people may be deprived of their liberty without the authorisation of due legal process.	Alison Kelly (CCG)	3	5	15	1. Rochdale Borough Safeguarding Adult Board (RBSAB) 2. Liberty Protection Safeguards (LPS) Working Group 3. Ongoing work with CHC/Adult Care to ensure issue remains a priority 4. Initial scoping of DoLs cases managed by Local Authority & scoping of potential LPS CHC eligible cases. 5. Regular monitoring & assurance provided to Greater Manchester Health & Social Care Partnership (GMHSCP). 6. System LPS preparation group in place (includes 16/17 year olds).	1. Review Guidance when guidance is issued to develop a workplan to implement.	A parliamentary Statement was released on 16.07.21 in relation to the Mental Capacity Amendment Act (2019) /Liberty Protection Safeguards (LPS). The original intention was for the LPS to be implemented in October 2020. The statement noted that this was no longer possible and that the aim is for full implementation of the LPS by April 2022 A draft code of practice and regulations will be made available in due course; the statement advises that this will happen well in advance of the target date.	RBSAB, LPS Working Group Governing Body, Audit Committee	None	Significant	3	4	12
SO1-069	**Losing staff due to uncertaintly around the development of the GM ICS**	Strategic Objective 1: To be high performing, deliver our statutory duties and use our available resources innovatively to deliver the best outcomes for our population	IF staff decide to leave employment due to the uncertainty around the development of the GM ICS THEN this will impact our ability to deliver our Locality Construct.	Rosemary Barker / Clare Nott	3	4	12	1. Regular updates provided at staff briefing sessions. 2. Regular briefings within teams 3. Communications and engagement linking in with GM to ensure consistent messaging include frequently asked questions 4. Continue to be fully engaged in GM construct work - The development of the locality construct is underway with clear links and reporting into the System Board and Integrated Commissioning Board with full participation from across the health and care system. 5. National HR Framework received and being worked through. 6. Pre-consultation period has just launched 7. Regular engagement opportunities with staff in place with all available methods. 8. Formal consultation period has begun. (from 1st April) 9. Access provided to CCG staff to the Council EAP for the 3 month consultation period.	1. Further develop locality construct 2. Mapping exercise to be completed for all staff in line with GM construct	1.Understanding of implications is currently limited but developing through the GM and locality construct work. 2. Staff wanting to leave due to organisational change 3. GM timeframes for implementation	1. Reports are regularly provided to Leadership teams and Governing Body 3. Reporting through LCO Board and System Board 4. Management through Workforce subgroup	None	Significant	3	4	12
SO1-064	**Implementation and embedding of learning from reviews of deaths of patients with learning disabilities and autism**	Strategic Objective 1: To be high performing, deliver our statutory duties and use our available resources innovatively to deliver the best outcomes for our population	IF there is not a local coordinator who reviews and implements/ embeds the learning from the review process THEN health inequalities for those with learning disabilities will not be addressed.	Alison Kelly (CCG)	5	5	25	1. Currently assigned to the designated safeguarding lead for adults as part of their wider role 2. Attending GM LeDeR Operational group 3. Attending GM LeDeR Project Group 4. Health check reviews take place annual with GPs - reviews of the process continues via task and finish group. 5. Quarterly Learning Disability newsletter for the system to raise awareness of local learning and action from learning	1. Identify additional individual to support or who would be better linked into the system	1. This work will be sitting under the GM ICS 2. GM Learning disability and autism programme board 3.Understanding of implications is currently limited but developing through the GM and locality construct work	1. LeDeR Steering Group 2. GM LeDeR Operational Group 3. Mortality Review group 4. Leading Disability Partnership Board 5. Rochdale Borough Safeguarding Adults Board 6. Local Governance panels and the ICS will be held accountable by NHS England & NHS Improvement for achieving the system objectives of service improvement.	None	Significant	3	3	9
SO6-007.c	**Escalating waiting times for autism assessment (Healthy Young Minds – children aged over 5 years)**	Strategic Objective 6: To deliver on the outcomes of the Locality Plan in respect of Children, young people and families	IF the demand for Autism Diagnostic Observation Schedule (ADOS) assessments remain high for children aged over 5. THEN this will delay timely diagnosis/support and is likely to negatively impact their education, health and life chances.	Charlotte Mitchell/Nadia Baig	5	4	20	1. Informal recovery action plan agreed with provider. 2. Escalated to Greater Manchester Integrated Care System (GM ICS). 3. Discussed at strategic level. 4. Assessment has now recommenced with the use of masks. 5. Staff working weekends to cover additional clinics which also now include non-ADOS trained staff undertaking initial assessments and DDH reviews. 6. Pennine Care are now undertaking structured observations to address waiting list. 7. Funding secured from GM to develop a new MDT autism team and plans are in mobilisation stage.	1. Working group has been established to design a Rochdale multi-disciplinary autism pathway and funding has been secured none recurrently from GM.	1. No trajectory has been included within the action plan to address how and when will then backlog will be recovered.	Children with Disabilities Partnership Risk, Finance and Performance Leadership SCCMB, GM Community Camhs Board, NHS England, CQC, Ofsted	None	Significant	3	3	9

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SO3-022	**COVID-19 mass vaccinations - vaccine inequality**	Strategic Objective 3: To deliver on the outcomes of the Locality Plan in respect of Neighbourhoods and Primary Care	IF vaccine uptake in some vulnerable population groups (including BAME communities and areas of deprivation) remains lower than local and national averages, THEN vulnerable members of the community will be at greater risk of serious illness and hospitalisation from COVID-19 and flu.	Sarah Crossley	5	4	20	1. The recent Booster programme in addition to increasing 1st and 2nd doses continues. 2. A whole-system vaccine inequalities group was established and an agreed group review and respond to the latest data on vaccine uptake and inequalities (these are measured at practice, neighbourhood and ethnicity or group level). 3. Reporting and assurance is via the Vaccine Oversight Group and Programme Board. 4. A number of targeted pop-up vaccine clinics and offers of vaccine in areas of low vaccine uptake continue to take place. 5. Neighbourhood work takes place on a regular basis and Health Champions and other community facing workers and volunteers are supporting vaccine uptake conversations with targeted groups - they are speaking to residents in targeted communities to encourage uptake.	Ongoing work to identify and tackle inequalities in coverage from existing and current focus on the booster programme to mitigate the risks of any reduction in protection and new variants.	1.Patient choice and vaccine hesitancy. 2.The infection rate of Omicron meaning significant numbers of the population are currently ineligible for the vaccine or booster for a further 28 days.	1. HMR Covid Vaccination Working Group, 2. Gold, 3. Silver 4. HMR Vaccine Inequalities Groups	None	Significant	3	3	9
SO1-066	**CCG Closedown - Electronic Management**	Strategic Objective 1: To be high performing, deliver our statutory duties and use our available resources innovatively to deliver the best outcomes for our population	IF there is not a network or shared repository for the storage of records, including an electronic records management file structure and adequate file plans in place for digital repositories. THEN this will lead to loss of assets or inability to access documents.	Chris Upton	4	4	16	1. Current structures are in place within the CCG. 2. Gain assurance from GMSS in the event of no consolidation of the locality structure e.g. Teams, local drives.	1. Head IT and assurance is sat of the GM Executive Board.	1. Awaiting direction from Greater Manchester	CCG Closedown Task & Finish Group Leadership Team Governing Body Audit Committee	None	Significant	3	3	9
SO1-068	**CCG Closedown - Patient facing record keeping.**	Strategic Objective 1: To be high performing, deliver our statutory duties and use our available resources innovatively to deliver the best outcomes for our population	IF there is not agreed funding and processes in place to transfer, store and retain legacy information for patient facing care records*. THEN there will be limited assurance and clarity where existing and future records will be kept and maintained. *records need to be kept according to the NHS Records Management Codes of Practice	Chris Upton/Paul Fox	4	4	16	1. Monitoring the emerging policies.	1. Engaging with GM with a view to being informed of any changes.	1. Awaiting direction from Greater Manchester	CCG Closedown Task & Finish Group Leadership Team Governing Body Audit Committee	None	Significant	3	3	9
SO6-007.e	**Surges in crisis demand for Acute Children's Mental Health Services**	Strategic Objective 6: To deliver on the outcomes of the Locality Plan in respect of Children, young people and families	If there continues to be an increase in the level of crisis presentations for Acute Children's Mental Health Services THEN there will continue to be an increase in waiting times for children and young people to access the core CAMHS community pathway pathways because the Children's Adolescent Mental Health Service (CAMHS) workforce will have to prioritise 7-day follow ups.	Charlotte Mitchell/ Nadia Baig	4	4	16	1. Regular meetings with Pennine Care. 2. Regular discussion at SCCMB. 3. Investment into crisis care pathways via GM. 4. Design of new models of care to support cared for children in crisis. 5. Development of new multi-agency MH pathway where Children's Social Care must follow an agreed process before escalation to commissioners.	1. Escalate to GM the need to develop an OPEL Dashboard to monitor system flow and pressures. 2. Discussions with provider around weekly pressures meetings with mental health. 3. Development of local MALM protocol. 4. Socialising with Children's services SMT. 5. Development of dynamic support process for Crisis MH.	None	SCCMB GM Crisis Care Board	None	Significant	3	3	9
SO4-011	**Infection Prevention Control (IPC) impact on capacity.**	Strategic Objective 4: To deliver on the outcomes of the Locality Plan in respect of In hospital - Planned (Getting more help)	IF the guidance for Infection Prevention Control (IPC) and/or the delivery of elective procedures is revised. THEN this will impact on the Trust's ability to deliver elective activity and will impact our ability to meet the National Target set within the Planning Guidance.	Nadia Baig/ Keeley Gibbons	4	4	16	1. Monitor progress against targets set nationally to inform action plan	1. Monitor impact of any changes to IPC and Social Distancing Guidance	Infection Prevention and Control measures are in place that need to be adhered to.	**Internal Assurance:** 1. Planned Care Programme Board **External Assurance:** Not applicable	None	Significant	3	3	9

					Inherent Risk								Residual		
Corporate Risk Register Ref	Risk Title	Strategic Objective	Risk Description	Risk Owner	Likelihood	Impact	Score	Mitigating Actions	Actions to further mitigate	Gaps in Controls	Assurance	Gaps in Assurance	Assurance Level	Likelihood	Impact	Score
SO3-006	**Primary Care Workforce**	Strategic Objective 3: To deliver on the outcomes of the Locality Plan in respect of Neighbourhoods and Primary Care	IF primary care demand continues to exceed capacity because of the combined impacts of a) COVID-19 on staff working patterns and operating models, b) recovering the backlog of care and c) embedding sustainable new ways of working, THEN this will increase pressure on other parts of the health and care system.	Sarah Crossley	3	5	15	1. Primary Care Mandate has a priority programme dedicated to primary care workforce resilience and retention with the Academy and CCG jointly leading this programme. 2. The HMR Primary Care Academy continues to support sustainability of the workforce through its programme of training and development. 3 Recruitment is underway for Additional Roles in primary care as part of the national PCN Additional Roles Reimbursement Scheme (ARRS). System work getting underway with all primary and community partners to look at opportunities to work collaboratively in the recruitment and retention of additional roles. 4. the HMR Primary Care Academy is implementing a programme of GP resilience with a focus on leadership development in middle-years GPs. 5. Fully embed workforce returns in general practice (HEE returns and Pulse Check processes) 6. The Academy has led on the development of a primary care workforce	1. Regular meetings with GMHSCP. 2. Increase of retention and recruitment activities through GP retention monies. 3. Keeping abreast of new and innovative roles which will compliment the GP role. 4. Robust data collection and monitoring of number of GPs, planned retirement and development of action plans to support recruitment and retention and introduce new roles. 5. Annual targets and payment made accordingly. 6. ARRS roles are difficult to recruit and embed, and require a lot of PCN development time. There is insufficient funding for ARRS role	1. National and GM shortage of health care professional roles.	1. Primary Care Workforce Mandate Delivery Group, 2. Quarterly ARRS submissions, 3. LCO Exec, 4. PCAT, 5.PCCC, 6. Regular assurance meetings between LCO, CCG and GM Workforce Group.	None	Significant	3	3	9
SO1-044	**Other Third Party Frauds (originating externally to the health body)**	Strategic Objective 1: To be high performing, deliver our statutory duties and use our available resources innovatively to deliver the best outcomes for our population	IF there is a rise in fraudulent activity and scams aimed at organisations and/or vulnerable people, due to the different organisational practices introduced since the pandemic began (e.g. cyber phishing, smishing and doorstep scams) THEN this will have a physical, emotional and financial impact	Damien Heakin/ Jonathan Evans	4	3	12	1. MIAA will be circulating regular alerts to all NHS staff to warn them of current and up-to-date threats and remind them to remain vigilant to them. 2. The CCG provides Fraud and cyber training to staff provided by the Head of IT and staff are informed via GMSS and ad hoc emails were Cyber threats are identified e.g. phishing emails.	None	Fraud/scams are still being reported.	Audit Committee	None	Significant	3	3	9
SO1-051	**Increased costs associated with changes in anticoagulant medication**	Strategic Objective 1: To be high performing, deliver our statutory duties and use our available resources innovatively to deliver the best outcomes for our population	IF more anticoagulant users are switched to Direct Oral Anticoagulant (DOAC's) which requires less monitoring but increase cost and the current anticoagulant service continues to support current service users THEN there will be additional prescribing costs and a financial impact to the CCG budget.	Keith Pearson	4	3	12	1. Move people to DOAC 2. Working with Pennine Acute around the impact of swapping medication on the anticoagulant service. 3. There is a national procurement programme in operation, HMR CCG has agreed to become part of this programme, this will reduce the costs of these treatments to the CCG. This only impacts some DOACs. PCNs are tasked with increased use of the nationally procured price on DOAC (Edoxaban)	1. Monitoring the situation quarterly and working with finance to understand the impact. 2. Develop a MOU between primary and secondary care to utilise the national procurement opportunities for DOACs to ensure the LCO sees the benefit of the programme.	1. Cant move everyone to DOAC straight away meaning that the anti coagulant service is still required. 2. GPs require guidance from the anticoagulant service to determine the most suitable DOAC. May require support from consultant haematologist	1. Commissioning meeting with Pennine acute - TBC 2. PCAT	None	Significant	3	3	9
SO1-057	**Management of the Implementation of the medicines optimisation team into the NCA**	Strategic Objective 1: To be high performing, deliver our statutory duties and use our available resources innovatively to deliver the best outcomes for our population	IF the Care Organisation fails to manage the Implementation of the medicines optimisation team into the NCA THEN this is a risk both for financial delivery of the budget and in the effective delivery of care.	Tabitha Gardner	3	4	12	1. Agreed through partner organisation. 2. Monthly meeting with partners 3. Internal meetings with D&P 4. staff being line managed within NCA 5. Existing team known to Head of Pharmacy for NCA 6. Risk share agreed – needs legal sign off	Legal advice to be sought - COMPLETED (August 2021)	Final arrangements for governance are ongoing, in particular ICS arrangements	1. Assurance to be provided to the People committee re TUPE 2. Ops performance and Finance	Legal sign off regarding risk share not yet completed	Significant	3	3	9
SO3-007	**Primary Care demand**	Strategic Objective 3: To deliver on the outcomes of the Locality Plan in respect of Neighbourhoods and Primary Care	IF primary care demand continues to exceed capacity because of the combined impacts of a) COVID-19 on staff working patterns and operating models, b) recovering the backlog of care and c) embedding sustainable new ways of working, THEN this will increase pressure on other parts of the health and care system.	Sarah Crossley	3	4	12	1. All GP practices have undertaken staff COVID-19 risk assessments and have embedded different delivery models including home-working and virtual-appointments. 2. Continued adherence to Infection Prevention and Control (IPC) guidance in primary care. 2. All practices have business continuity plans 4. All practices have formed buddying arrangements with other practices to boost resilience. 5. Funding has been provided in 2020/21 for Covid-related estates improvements to make practices safe for patients and staff. 6. Additional GP resilience funding from NHS England has been paid to all practices to assist them to increase GP numbers and workforce capacity. 7. Twice weekly Pulse Check (sit rep) reporting, with targeted CCG support for practices who are struggling. 8. Well While you Wait programme being led by Pennine Acute to include primary care representation 9. A 100% triage model has been implemented across all practices in HMR and GPs continue to see urgent appointments that required a face to face appointments based on clinical need. 10. Winter Access Funding is being rolled out in general practice to provide additional capacity and greater resilience, until March 2022. This funding is also being used to commission Primary Care Hubs at Whitehall St and the Phoenix Centre.	1. Continue to monitor 2. Commissioning extra capacity via Whitehall Street PCN hub	1. Not possible to accurately measure or control level of demand	1. PCAT, 2. GOLD, 3. SILVER 4. PCCC, 5.GM Primary Care cell and Community care cell	None	Significant	3	3	9
SO3-018	**COVID-19 mass vaccinations - service specification and timescales for mobilisation**	Strategic Objective 3: To deliver on the outcomes of the Locality Plan in respect of Neighbourhoods and Primary Care	IF the release of guidance for and COVID-19 vaccination programmes continues to be provided by NHS England with very short timescales for implementation. THEN the current longer term plans for the COVID-19 programme are unknown at the present time	Sarah Crossley	4	3	12	1. Operational groups are in place to enable pre-planning and rapid mobilisation - these include vaccine working group fortnightly, Clinical Leads catch-up weekly, Health inequalities fortnightly, Gold weekly. Also weekly GM SRO meetings. 2. Dedicated vaccine programme and project managers in place to support delivery. 3. Continue daily oversight of programme delivery and emerging guidance	1. Commencing planning for options and scenarios post April 2022. 2. GM Surge planning in progress and locality planning to follow.	1. National guidance fluid and emerging	1. HMR Covid Vaccination Working Group, 2. Gold, 3. Clinical Leads, 4. Health Inequalities, 5. GM SRO meetings, 6. HMR Flu delivery group, 7. Health protection board	None	Significant	3	3	9

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Corporate Risk Register Ref	Risk Title	Strategic Objective	Risk Description	Risk Owner	Likelihood	Impact	Score	Mitigating Actions	Actions to further mitigate	Gaps in Controls	Assurance	Gaps in Assurance	Assurance Level	Likelihood	Impact	Score
SO3-030	**Primary care access to diagnostic tests**	Strategic Objective 3: To deliver on the outcomes of the Locality Plan in respect of Neighbourhoods and Primary Care	IF GPs continue to not have full access to diagnostic tests and results in a timely manner THEN there is a clinical risk to patient care	Sarah Crossley	3	4	12	1. Planned care commissioner continuing to work with the Laboratories 2. Communication with GPs regularly around delays and access 3. Primary care team escalated to planned care commissioner to pick up within their contracts. 4. GPs encouraged to report via Ulysses and robust processes in place to follow up.	1. Monitor progress 2. see risk SO4-009 planned care risk	1. Capacity within the labs and diagnostic facilities	1. PCAT, 2. Planned care board	None	Significant	3	3	9
SO1-058	**Inability to financially plan beyond 22/23**	Strategic Objective 1: To be high performing, deliver our statutory duties and use our available resources innovatively to deliver the best outcomes for our population	IF there continues to be uncertainty regarding the financial decision-making responsibilities at locality and GM level. THEN we will not have the level of flexibility needed to reallocate funding, which could impact planning of service provision in the locality.	Jonathan Evans /System DOFS	4	5	20	1. Discussion paper on Financial Flows produced 2. Key assumptions agreed 3. Key principles to support financial flows and financial management agreed 4. Draft financial flow proposals developed	1. Review of all contracts to ensure value for money and exit clauses. 2. Work closely with providers and LCO to fully understand activity, costs, and future capacity plans 3. The GM Provider Directors of Finance and CCG CFOs have worked collaboratively to model the GM system financial models and develop mitigation plans and areas of GM efficiencies to manage within a system control total for the period 2022/23. This will be monitored through the GM CFO meeting in year. 4. Work to continue across GM including: a. Financial flows b. Financial regime within GMICS c. National Financial Framework	Finance workstream is highly dependant on other workstreams determining the overall approach to decision making and spatial approach as well as any national guidance	1. CFO joins fortnightly regional meetings and weekly GM CFOs where this is regularly discussed. 2. Regular updates to FPR, ICB , Audit Committee and Governing Body. 3. Reporting through LCO Board and System Board 4. NHSE	None	Significant	2	4	8
SO6-053	**Limited data submitted by provider in relation to child development outcomes (ASQ data and 0-5 mandated contacts)**	Strategic Objective 6: To deliver on the outcomes of the Locality Plan in respect of Children, young people and families	The ASQ* data for Q2 21/22 was unavailable to submit due to a system change in in NCA (*data and 0-5 mandated contacts) IF this continues THEN we will be: a) unable to comply with national reporting requirements b) unable to strategically assess the impact of the pandemic and deploy resources to respond to need as appropriate. *population measure of child development	Lianne Davies / Kuiama Thompson (Adam Sutcliffe)/ Zeph Curwen	4	4	16	Initial indication provided by NCA that the issues with the system will be rectified by June 2022. Local colleagues are working together to expedite these timescales.	NCA have agreed to further escalate within the organisation to resolve		Recovery and Quality Group (members NCA and commissioners)	None	Significant	2	4	8
SO1-033	**Cyber Security Risk**	Strategic Objective 1: To be high performing, deliver our statutory duties and use our available resources innovatively to deliver the best outcomes for our population	If spam emails are received through NHS mail, then there is a risk that malware is introduced and unauthorised users may gain access to CCG networks.	Chris Upton	2	4	8	1. Further cyber security training has been provided to all staff on phishing and malicious email campaigns by the CCG IT lead. 2. The CCG's IG lead regularly distributes communications through team brief on cybersecurity risks in particular on the use of email to ensure staff are aware of the risks around phishing and spam emails and how these should be dealt with and reported nationally . 3. Additionally when specific phishing email threats emerge the IG lead notifies CCG staff via comms. 4. All staff are required to complete annual mandatory training which includes awareness around cybersecurity risks. 5. The CCG is required to provide evidence of these activities in the Data Security and Protection Toolkit. 6. Additional training has been provided to CCG teams by the CCG IT lead on cyber security including specific vulnerabilities and treats to the CCG and Primary Care. 7. NHS Digital Testing	Periodic and regular updates for new starters	Staff compliance with training.	IM&T Board	None	Significant	2	4	8
SO6-006	**Increase in Safeguarding Concerns post lockdown**	Strategic Objective 1: To be high performing, deliver our statutory duties and use our available resources innovatively to deliver the best outcomes for our population	If there is increased demand in Children's Social Care, then this will impact upon statutory duties of universal health services (School Nursing Team) to prioritise and respond to the needs of children where there are safeguarding concerns/ or cared for children. This will place further pressures on Children's Health Services. Surge data provided from children's social care evidenced significant increase in referrals and acuity of need. There will be an increased reliance on health professionals to initiate and hold children at Early Help level where identified and to contribute to safeguarding plans.	Adam Sutcliffe	5	4	20	1. Additional investment in the school nursing service has been agreed between Public Health and NCA. This will enable a pilot project to be implemented that involves the creation of a dedicated safeguarding staff team within school nursing and increasing capacity to deliver the public health interventions, the Healthy Child Programme and Early Help. Implementation is currently underway. Regular implementation meetings in place between NCA, Public Health and HMR CCG Safeguarding.	1. Continue with the full implementation of the new staffing model in school nursing, delayed but still ongoing due to the Nursing Service deliver the 12-15 year old Covid Vaccination Programme during the first school term and post Christmas term. 2. 3.5 out of 5 posts have candidates appointed. Recruitment of the additional staff to support the model is ongoing. 3. Work is underway to jointly define the outcomes we will monitor to assess the impact of this way of working. 4. Determine utilisation of additional spend during the next mobilisation meeting. 5. Develop plan for post proof of concept period for sustaining model.	None	1. CYPP 2. Oversight from FSM Board	None	Significant	2	3	6

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Corporate Risk Register Ref	Risk Title	Strategic Objective	Risk Description	Risk Owner	Likelihood	Impact	Score	Mitigating Actions	Actions to further mitigate	Gaps in Controls	Assurance	Gaps in Assurance	Assurance Level	Likelihood	Impact	Score
SO1-042	**CHC and PHB Frauds**	Strategic Objective 1: To be high performing, deliver our statutory duties and use our available resources innovatively to deliver the best outcomes for our population	IF the Personal Health Budget (PHB) holders provide medical and nursing staff with information to fraudulently obtain more resources and IF suppliers providing services to those clients with a Continuing Health Care (CHC) budget issue fraudulent or duplicate invoices. THEN this will have a negative financial impact on the funding organisation.	Damien Heakin/ Jonathan Evans	3	3	9	1. Locally, All CHC claims are monitored by the CHC team and checked by the finance team to ensure that they are authorised correctly and not subject to fraudulent claim. 2. Invoices are checked prior to authorisation.	None	None	Audit Committee	None	Significant	2	3	6
SO1-043	**Primary Care Contractor Frauds**	Strategic Objective 1: To be high performing, deliver our statutory duties and use our available resources innovatively to deliver the best outcomes for our population	IF Primary Care Contractors (i.e.GP, pharmaceutical, dental and ophthalmic care and primary care services) purposefully misreport activity for services delivered or do not keep accurate records including those of patient list sizes which determines the capitated budget for GP practices THEN this will have a negative financial impact on the funding organisation.	Damien Heakin/ Jonathan Evans	3	3	9	1. Historically the NHS has had good systems and processes to monitor its primary care contractors and their activity. Locally, depending on the need to develop and expand primary care, CCGs may have taken different approaches to that requirement. 2. All payments to Primary Care are checked by the Primary Care team and secondly by the finance team to ensure they are authorised correctly and no fraudulent claims are made. 3. Any probity concerns over the national dental/ ophthalmic contract payments and claims should be referred to NHS England fraud team, the Local Counter Frauds Service (LCFS).	None	None	Audit Committee	None	Significant	2	3	6
SO6-007.a	**Increase in children with complex needs requiring specialist residential placements**	Strategic Objective 6: To deliver on the outcomes of the Locality Plan in respect of Children, young people and families	If there is an increase in the number of looked after children with complex needs which require residential placements, then this will result in a need to jointly fund placements and place children out of area if local capacity cannot meet demand. This may place significant pressure on CCG budgets.	Charlotte Mitchell/ Nadia Baig/ Julia Hassall	3	3	9	1. Implement the recommendations following the review of the Multi Agency Complex Needs Panel (MACNP). 2. Placement officers to move to CCG leadership to ensure outcomes framework implementation. 3. Number of projects are underway to increase local sufficiency; Supported lodgings/Enhanced Fostering/ No Wrong Door Model/Ealing Model; QA function replacements; SMART targets for care plans provided by placements ;Therapeutic intervention locally resulting in reduction in external requirements.	1. Dynamic Support Process 2. Capital bid for Learning Disabilities & Autism (LDA) Unit. 3. Specification from commissioning for cared for children therapeutic provision.Market/Provider engagement events 4.Sustainability of health post in the No wrong Door project.	Cannot control the number of children requiring residential care.	1. Children's Services SLT 2. CYPP	None	Significant	3	2	6
SO1-055	**Changes to lower carbon inhaler for asthma patients incurring increase costs**	Strategic Objective 1: To be high performing, deliver our statutory duties and use our available resources innovatively to deliver the best outcomes for our population	IF the policy to switch asthma inhalers to a lower carbon inhaler and the DES includes a payment for this in primary care THEN there will be a significant impact on the CCG budget as we are not aware of any national funding to support the transition	Keith Pearson	3	3	9	1. Monitor whether the Primary Care Networks commence system-wide inhaler swaps to determine the financial impact as the environmentally friendly/powder alternative is higher cost. 2. A paper was discussed at Governing Body in November. The potential increased costs have were shared with finance colleagues. This came with a significant financial cost increase and finance colleagues are aware 3. Patients now coming back into primary care and therefore the policy is beginning to be implemented locally. Remains within the PCN who are incentivised to changeover the inhalers.	1. Monitor PCN roll out on a quarterly basis understand the financial impact.	1. National policy 2. Andy Burnham policy for GM carbon reduction 3. PCN DES if decide to roll out full programme at pace. PCNs are incentivised to do this. 4. The rate of changeover to lower carbon inhalers per PCN.	1. Respiratory Steering group 2. LEG 3. Primary Care Assurance and Transformation Committee	None	Significant	2	3	6
SO3-025	**Core + contract impact on CCG budget**	Strategic Objective 1: To be high performing, deliver our statutory duties and use our available resources innovatively to deliver the best outcomes for our population	IF we are unable to have a core + contract in place and are unable to go into practices to support them to prescribe appropriately THEN the CCG budget pressures will increase at a rate of 4% per annum	Keith Pearson	3	3	9	1. Identification of saving opportunities 2. The Medicines Optimisation Team are now engaging with PCNs to determine current plans for improving clinical and cost effective prescribing for the remainder of the financial year. There will be some changes in the capacity of the Meds opt Team for Q4 2021/22 and for 22/23	1. Develop an incentive for GPs to remain within prescribing budget if core + contract not confirmed.	1. No contract or agreement in place within primary care	1. Primary Care Assurance and Transformation Committee	None	Significant	2	3	6

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SO2-003	**Increased transmission of the COVID-19, risk to health and life**	Strategic Objective 2: To deliver on the outcomes of the Locality Plan in respect of P&A (Prevention and Self Care)	IF community transmission rates increase from a new variant of concern THEN there is a risk of increased morbidity and ill health.	Kuiama Thompson/ Anthony Threlfall	3	3	9	1. Current government advice is that the impact can be lowered with vaccine boosters. An enhanced Booster programme and vaccination programme remain in place implemented in line with guidance. 2. Outbreak Plan has been updated and is maintained and ready to respond to emerging trends. 3. Testing is available 4. Plans have been implemented to increase system resilience especially around staff	1. Continued delivery of the outbreak plan 2. Development of the Prevention and Inequality Strategy and Plan 3. Increase uptake of booster jabs 4. Increase uptake of flu jab	1 Awaiting national long term covid management plan. 2.National guidance re social distancing, mask wearing etc. 3. Combined impact of flu & covid on hospitalisations/ morbidity 4. Further Non Pharmaceutical Interventions- (NPIs) involving controls on social mixing are likely to be required alongside 'best efforts' at booster vaccination uptake in order to mitigate the high risk of cases and further possible hospitalisations and deaths (both nationally and locally).	1. Gold and Silver Groups are in place 2. Reports are regularly provided to Leadership teams and Governing Body as the pandemic progresses 3. Reporting through LCO Board and System Board 4. Health Protection Partnership	None	Significant	3	2	6
SO3-024	**Transition to Integrated Commissioning System within Primary Care**	Strategic Objective 3: To deliver on the outcomes of the Locality Plan in respect of Neighbourhoods and Primary Care	IF there is an organisational restructure process and this does not have clear guidance for organisation e.g. CCG and GP Federation THEN the transition will result in delays and uncertainly which could impact on the planning, commissioning and delivery of local commissioned services (LCS)and GP contract management.	Sarah Crossley	3	3	9	1. CCG to work with contract colleagues and providers to ensure the contracts and risks are captured in LCO and ICS development plans. 2. Commissioning intentions 3. Robust internal communication with finance, senior level executives and clinical leads	None	1. Lack of clarify of ICS structures	1. LCO Exec, 2. PCCC, 3. Director Management Oversight Group DMOG (GMHSCP)	None	Significant	2	3	6
SO3-028	**Primary care estates**	Strategic Objective 3: To deliver on the outcomes of the Locality Plan in respect of Neighbourhoods and Primary Care	IF general practice and primary care estates are not fit for purpose THEN there will be an impact on quality and safety of service delivery to patients and staff.	Sarah Crossley	3	3	9	1. Strategic estates group regularly monitor and assess practices 2. Developing PCN and LCO estates strategy 3. Support PCNs and GP practices with improvement bids 4. Operational estates group	None	1. NHS England have limited funding for primary care estates improvement programme	1. Strategic Estates Group, 2. PCCC, 3. PCAT, 4. Monthly estates catch up with strategic executive estates lead	None	Significant	2	3	6
SO3-029	**Primary care clinical consumables supply**	Strategic Objective 3: To deliver on the outcomes of the Locality Plan in respect of Neighbourhoods and Primary Care	IF global supply chains remain interrupted by COVID-19 and Brexit, THEN this will mean shortages of key consumables and impact on patient care e.g. a shortage of blood vials means that blood tests are rationed, potentially delaying the diagnosis of a serious health conditions.	Sarah Crossley	3	3	9	1. Implement mutual aid across HMR health and care system 2. Rapid sharing of national and GM comms, and development of local communications with CCG/RHA/LMC 3. Escalation to GMHSCP	None	1. Supply and logistic delays	1. LCO Exec, 2. PCAT	None	Significant	2	3	6
SO2-005	**Home Oxygen Use Where Smoking Risks Have Been Identified**	Strategic Objective 2: To deliver on the outcomes of the Locality Plan in respect of P&A (Prevention and Self Care)	IF the number of long term oxygen users continue to smoke, use e-cigarettes or other household members who continue to use smoking materials continue to increase THEN there is a risk to the safety of the service user and the whole household and adjacent properties.	Keith Pearson	3	3	9	1. When Bayswater (Home Oxygen provider) resumes home visits smoking risks at each household will be identified by the provider and an action plan put in place. 2. Zero policy on household smoking, if the household continue or refuse to stop smoking then the oxygen is removed. No concerns are being raised with the Home Oxygen Regional Lead at the present time	1. Request data once home visits resume. 2. Home Oxygen Assessment Service (HOAS) to provide assurance of zero policy being implemented and actions being implemented once smoking identified. 2. Link into Stop Smoking service to provide support when required	1. Patient / household willingness to stop smoking/using smoking material 2. Until BAU with household visits we cant control the smoking within the household	1. Quality & Safety Committee	None	Significant	2	3	6
SO3-004	**Neighbourhood and PCN alignment**	Strategic Objective 3: To deliver on the outcomes of the Locality Plan in respect of Neighbourhoods and Primary Care	IF PCNs continue to not be coterminous with existing INTs THEN it may result in operational difficulties.	Sarah Crossley	5	2	10	1. INT teams meeting with PCNs on a regular basis. 2. PCNs to implement processes/mechanisms to facilitate close working between PCNs, INTs, CD and INT Team leaders 3. To actively monitor and manage alignment between PCNs and INTs	1. Ensuring strong PCN representation in locality construct meetings 2. Neighbourhood board to pick up governance routes 3.Regular contact and developing operational process to manage workload	1. Governance routes separate at present	1. LCO Exec, 2. SMT/Portfolio Board, 3. PCAT, 4. regular assurance meetings between LCO and CCG, 5. PCCC	None	Significant	5	1	5

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SO3-021	**COVID-19 mass vaccinations - vaccine supply**	Strategic Objective 3: To deliver on the outcomes of the Locality Plan in respect of Neighbourhoods and Primary Care	IF there is insufficient supply of COVID-19 and flu vaccines to meet government targets for vaccination of priority groups, THEN members of the population will not have equitable access to a vaccine	Sarah Crossley	3	4	12	1. Detailed system modelling of vaccine requirements and vaccine delivery are in place and shared across the system daily, and includes delivery by age and Clinically Extremely Vulnerable cohort. 2. Pinnacle vaccine delivery is entered within 24hours to ensure data is accurate and up to date. 3. Vaccine supply is still being driven by NHS England however it has now moved to a capped pull model which allows more flexibility and control for our Local Vaccine Sites 4. There are borough wide forums in place to ensure we continue to target hard to reach cohorts as well as looking at the Lower Super Output Area data to identify areas of HMR with low uptake 5. HMR consistent approach 6. Modelling data available for the eligible cohorts 7. Weekly HLR to GOLD updating the supply and capacity tracker 8. GM have a system in place to redistribute vaccine supply.	None	1. National guidance fluid and emerging	1. HMR Covid Vaccination Working Group, 2. Gold, 3. Clinical Leads meeting weekly, 4. PCN colleagues.	None	Significant	2	2	4
SO3-027	**Primary care - respiratory diagnostics**	Strategic Objective 3: To deliver on the outcomes of the Locality Plan in respect of Neighbourhoods and Primary Care	IF there remains a lack of respiratory diagnostic testing in primary care, THEN this will impact on the quality of diagnosis of respiratory conditions and potentially reduce the effectiveness and efficacy of patient care, as well as putting additional pressure on secondary care for diagnostic tests.	Sarah Crossley	4	3	12	1. Respiratory Steering Group has oversight of the respiratory diagnostic programme 2. Exec/PCAT have approved a paper to restart FeNO testing (to detect inflammatory disease, Asthma) in primary care. Service go live October. 3. Planning underway for development of a borough wide spirometry offer 4. Development of a respiratory diagnostic pathway 5. Implementation of Diagnostic Hubs across GM in 22/23	None	1. No dedicated funding to deliver new models of diagnostic tests. 2. No control over GM planning for diagnostic hubs (both delivery timescales and inclusion criteria). 3. This is a national delivery problem as spirometry is aerosol generating.	1. HMR Respiratory Steering Group, 2. PCAT, 3. HMR Planned Care Board, 4. PCCC	None	Significant	2	2	4
SO3-032	**Advice and Guidance**	Strategic Objective 3: To deliver on the outcomes of the Locality Plan in respect of Neighbourhoods and Primary Care	IF the LCO does not improve access to phone and/or eRS advice and guidance (A&G) for GPs THEN HMR will remain one of the worst performers nationally for A&G. This *may* impact on decisions about patient care and create avoidable pressure on urgent and planned care	Sarah Crossley	4	3	12	1. A&G identified as a scheme using Community SDF Funding, as well as funding being in place in LCO budget. 2. Project plan to co-developed by LCO and CCG leads. 3. Monthly meetings with PAHT eRS A&G Lead Health and Care at Home, Planned Care Board, UEC Board, LCO Exec CCG does not have direct control over PAHT's ability to providers or phone-based A&G.	None	1. CCG does not have direct control over PAHT's ability to providers or phone-based A&G	1. Health and Care at Home, 2. Planned Care Board, 3. UEC Board, 4. LCO Exec	None	Significant	2	2	4
SO1-054	**Lack of clarity on the division or responsibilities between the LCO Board and System Board**	Strategic Objective 1: To be high performing, deliver our statutory duties and use our available resources innovatively to deliver the best outcomes for our population	IF there is a lack of clarity on the division of responsibilities between the System Board and the LCO Board THEN there is a risk of duplication, gaps in governance and lack of ownership	Steve Rumbelow/ Steve Taylor	3	4	12	1. Development of TOR for the LCO Board, System Board and subcommittees now underway in draft format 2. Shadow system in place to test arrangement prior to formal roll out 3. Agreement through operating model for set of agreements between System Board (once established) and LCO Board/Provider Lead arrangements	1. On-going review of governance arrangements once established. 2. Engage with all partners to ensure collaborative agreement on the division of responsibilities 3. Sign off ToR for Board and Sub-Committees	Agreement and sign off of TOR for Board and subcommittees not yet happened - due September 2022	Reporting through Shadow LCO Board and LCO Executive and System Board	There are gaps in the development of the formal governance arrangements but the plans for this are in train as per the controls	Significant	1	4	4
SO1-004	**NHS Financial Systems & Performance (invoices, procurement etc.)**	Strategic Objective 1: To be high performing, deliver our statutory duties and use our available resources innovatively to deliver the best outcomes for our population	IF the pandemic leads to an increase in NHS organisations being subject to Bank Mandate Fraud, False Accounting and Invoicing and Procurement fraud THEN without strict processes, procedures and training in place this could continue and have a negative financial and reputational impact on the organisation.	Damien Heakin/ Jonathan Evans	3	3	9	1. Robust processes in place for finance teams and senior level staff to verify and authorise any requests for changes to bank mandate details. 2. All are aware of and adhere to internal procedures and controls to minimise the risk of losses to this type of fraud. 3. Financial controls are in place to obtain robust evidence of all provider claims made in order to ensure that said claims are being paid correctly. 4. Governing Body monitors finances	1. Adherence to policies and procedures. 2. Policies have been reviewed and amended to reflect the effect of COVID-19 on BAU processes including senior-level oversight and clear guidance for the finance team.	None	Risks are reported through to Finance, Performance and Risk and Governing Body.	None	Significant	2	2	4
SO6-011	**Failure of SEND Joint Inspection due to increasing waiting times**	Strategic Objective 6: To deliver on the outcomes of the Locality Plan in respect of Children, young people and families	If sufficient progress is not made in SEND then we will fail compliance for Ofsted/CQC inspection visits.	Charlotte Mitchell/ Nadia Baig	3	3	9	1. Designed an audit tool for disabled children to map against compliance requirements. 2. Developing an improvement action plan to support progress against compliance. 3. NCA have recruited permanent OT post utilising waiting list monies that have been agreed by the CCG. SLT still out to advert. 4. Commissioners and LA have secured funding and contracted IMPOWER to re-design Rochdale's integrated therapies offer. Work to commence 1st February. 5. New SEND alliance will be operational in shadow form from October 2021. 6. None re-current funding has been secured to further enhance waiting list initiatives. 7. Funding secured for SEND quality assurance post in local authority to support inspection readiness.	1. Launch of send alliance - 8th Feb 2. Launch of send strategy - 1st Feb 3. Recruitment of SLT post 4. Design of community autism assessment model 5. Integration of SLT and OT/launch of IMPOWER project.	Recruitment. Autism assessment recommencing.	1. SCCMB 2. Risk Escalated to CYPP and Leadership	None	Significant	2	2	4

					Inherent Risk									Residual		
Corporate Risk Register Ref	Risk Title	Strategic Objective	Risk Description	Risk Owner	Likelihood	Impact	Score	Mitigating Actions	Actions to further mitigate	Gaps in Controls	Assurance	Gaps in Assurance	Assurance Level	Likelihood	Impact	Score
SO1-015	**Drug Tariff Category M Drug Prices and implications for the CCG prescribing budget**	Strategic Objective 1: To be high performing, deliver our statutory duties and use our available resources innovatively to deliver the best outcomes for our population	IF there continues to be medicine shortages on the 'No Cheaper Stock Obtainable' (NCSO) list. This is currently unpredictable which medicines are included on that list on a weekly basis. THEN There will put pressure on the prescribing budget	Keith Pearson	3	3	9	1. Costs are being monitored through the GM Shared Services BI portal and appear to be relatively stable at this time	1. Continue to monitor the costs.	1. Additional medicines are added to the NCSO list 2. National price dictation	1. Primary Care Assurance and Transformation Committee	None	Significant	2	2	4
SO3-031	**Community Service Development Funding**	Strategic Objective 3: To deliver on the outcomes of the Locality Plan in respect of Neighbourhoods and Primary Care	IF there is not consistent guidance from NHS England about the criteria for Community SDF funding and whether the funding is recurrent THEN this creates a risk that schemes need to be adapted after mobilisation and cannot be sustained beyond 22/23	Sarah Crossley	3	3	9	1. Following community SDF guidance as set out in 21/22 planning guidance 2. Monthly catch-ups with Aging Well and 2h Community Response NHS England GM Leads 3. Details of schemes shared with GM Leads 4. Only short-term 'test of change' initiatives are being funded in 21/22 while we await information on recurrent funding	None	1. Detailed guidance not yet issued by NHS England	1. Health and Care at Home, 2. UEC Board, 3. LCO SMT, 4. LCO Exec	None	Significant	2	2	4
SO4-058	**Patients choosing to wait before having procedures.**	Strategic Objective 4: To deliver on the outcomes of the Locality Plan in respect of In hospital - Planned (Getting more help)	IF patients choose to remain on waiting lists for future treatment in hospitals THEN there will be a growing number of people with long waits	Nadia Baig/ Keeley Gibbons	3	3	9	1. Waiting list, waiting times and activity for all in scope specialties are monitored as part of Project Delivery Groups (Cardiology, Respiratory, Ophthalmology and MSK). 2. NHSE 22/23 planning guidance asks for all 104 week waiters to be eliminated by Mar 23. The guidance recognises that patients may chose to wait and therefore excludes these patients from the Mar 23 target.	1. Work with Primary and Secondary Care to agree referral pathways for in-scope specialities/ conditions 2. Develop 'While You Wait' Programme 3. Further understand the breakdown of patients waiting long periods, what they are waiting for and if they have chose to remain on the list. 4. Where patients opt to defer their treatment all evidence of patient choice in line with Access targets this is clearly recorded on all systems for visibility and transparency	Patients have the right to choose to wait for treatment.	**Internal Assurance:** 1. Planned Care Programme Board **External Assurance:** Not applicable	None	Significant	1	4	4
SO1-032	**Cyber Security Risk**	Strategic Objective 1: To be high performing, deliver our statutory duties and use our available resources innovatively to deliver the best outcomes for our population	If domain machines are not adequately patched then there is a risk that software vulnerabilities can be exploited.	Chris Upton	2	4	8	1. Cyber Security action plan continues to be monitored through the GM IT Security group. 2. USB Port Blocking now being run on all HMR CCG and GP machines with a whitelist of any secure devices in use. 3. Administration rights on all GP machines restricted to IT support staff only. 4. The CCG must approve any new software being installed across the estate. 5. All software updates are continuing to be rolled out on a monthly basis (sooner if the need arises). 6. CareCERT notifications are being monitored and acted upon when raised by GMSS with the CCG receiving notifications. 6. All CareCERT alerts now formally reported on through IT Security Group. 7. Cyber Security is now being reported on a 6 monthly basis to Governing Body via Information Governance Management Group. 8. A recent programme of upgrades has been conducted to ensure all CCG laptops are running the Windows 10 operating system. 9. To ensure machines are adequately up to date, any computer that has not connected to the network for 90 days is locked until it reconnected and thereby receives patches and updates.	None	Individual staff following IT processes.	IT Security Board. Quarterly Security Board report detailed incidents and assurances on level of patching.	None	Significant	1	4	4
SO3-009	**Primary Care Contracts**	Strategic Objective 3: To deliver on the outcomes of the Locality Plan in respect of Neighbourhoods and Primary Care	A) IF robust internal general practice arrangements are not in place THEN there is an increased risk of relationships breakdown that this will impact on patient service as this makes them less resilient and sustainable moving forward. B) IF we continue to have single handed GP business model THEN there is a risk to continuity of service to patients	Sarah Crossley	2	4	8	1. The CCG work closely with its member practices to support resilience and sustainability with the support of external parties where appropriate such as the Local Medical Committee, legal teams etc. 2. Quality Programme includes checks of contractual requirements/partnership agreements and continues to promote need for robust partnership agreements 3. Support single handed business with business continuity 4. Going forward no longer issue single handed contract.	1. CCG level continuity plan in development along with detailed project plans in place for action that may need to be taken, 2. Escalation to senior management team, 3. Ad-hoc PCCC meeting can be put in place for emergency decision making	1. Unforeseen issues of an urgent nature where there is an immediate need to ensure primary medical services could continue for this population. 2 x HMR practices are still run by single-handed GPs.	1. PCAT 2. PCCC 3. Governing Body	None	Significant	2	2	4
SO1-010	**Generic fraud risk**	Strategic Objective 1: To be high performing, deliver our statutory duties and use our available resources innovatively to deliver the best outcomes for our population	IF there is an act of fraud being perpetrated against the health body, whether internal, external or collusive, being either opportunistic or organised, isolated or on-going THEN This could have financial or reputational impact on the CCG.	Damien Heakin/ Jonathan Evans	3	2	6	1. Established Financial Controls 2. Comprehensive 'Fraud-Proofed' Policies and procedures 3. Internal and External Audits 4. Dedicated Anti-Fraud Specialist in post 5. Risk-assessed Anti-Fraud Work plans 6. NHS CFA Anti-Fraud Guidance and Alerts disseminated and actioned 7. Embedded Anti-Fraud Culture which has been developed over time.	Processes policies and culture embedded into BAU and forms part of Mandatory training.	None	Audit Committee	None	Significant	2	2	4

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SO1-041	**Commissioning Frauds**	Strategic Objective 1: To be high performing, deliver our statutory duties and use our available resources innovatively to deliver the best outcomes for our population	IF current processes for timely commissioning of services to support the pandemic response continue alongside the block contracting arrangements set nationally THEN there will continue to be a lack of flexibility in where resources can be most effectively allocated.	Damien Heakin/ Jonathan Evans	3	3	9	1. The CCG have established systems and processes already in place via its Scheme of Reservation and Delegation (SORD) to authorise payments. 2. In some CCG's exceptional/ urgent payments due to COVID-19 have been authorised by their leadership teams and or committees established to approve urgent payments. 3. Given the change in the NHS financial regime the CCG seeks evidence, verification and assurance over extra funding requests from Trusts for COVID-19 expenditure. Significant sums of public money are highly likely to be involved and CCGs need to assure themselves over the probity of the claims received from NHS and where appropriate from private contractors. Where any concerns of fraud are identified the LCFS should again be contacted for advice and support. 4. The CCG has robust systems in place through the scheme of reservation and delegation to ensure payments are authorised.	None	None	Audit Committee	None	Significant	1	3	3
SO1-063	**Medicines Optimisation Team- workforce**	Strategic Objective 1: To be high performing, deliver our statutory duties and use our available resources innovatively to deliver the best outcomes for our population	If members of the Medicines Optimisation team leave the CCG THEN recruitment will need to take place to fill permanent positions required to complete all duties.	Keith Pearson	4	2	8	1. 12 month secondment going out for KP's role / or a retire and return option dependant on board approval. 2 . Board approval given for a retire and return, KP to be retained on 16 hours / week for up to 6 months	1. Possibility of looking to recruit to the maternity leave, though unlikely	1. Unlikely to get anyone to cover the maternity leave 2. No plans to recruit backfill to support member of staff on sick leave following surgery 3. Long term plan for recruitment to KPs role	Managed locally, Workforce committee	None	Significant	3	1	3
SO1-034	**Responding to Freedom of Information requests**	Strategic Objective 1: To be high performing, deliver our statutory duties and use our available resources innovatively to deliver the best outcomes for our population	If the CCG fails to respond to Freedom of Information requests appropriately, with valid exemption (where required) and within 20 working days, THEN it will not meet its statutory duties and it may result in a decision notice being issued by the Information Commissioner, leading to external scrutiny and remedial action having to be taken.	Rob McDougall	1	3	3	1. Robust process in place to ensure that FOI s are sent to correct person to generate a response and ensure that the20 working day response target is met.	As part of the CCG's FOI process, an escalation process is in place to ensure that any overdue FOI information responses are chased on the first day they become overdue. Whilst the Freedom of Information Act 2018 allows 20 working days for an organisation to respond to a request, CCG processes are geared towards responding to requests quickly. Between 1/4/2020 and 31/3/2021, the CCG's average response time was 9 working days and 100 % of requests received were responded to in 20 working days.	FOI information responses not being received in the required time, despite escalation to Directors.	Governing Body	None	Significant	1	3	3
SO1-008	**Patient Frauds**	Strategic Objective 1: To be high performing, deliver our statutory duties and use our available resources innovatively to deliver the best outcomes for our population	IF patient frauds occur (e.g. prescription frauds, oversee patient fraudulently accessing care in England, patients posing as medical professionals to steal supplies/drugs) THEN this will have a negative financial impact and potentially lead to legal charges being brought against patients/residents.	Damien Heakin/ Jonathan Evans	2	2	4	NHS organisations should report any known individuals to NHS England and/or the Police in order for appropriate action to be taken. NHS organisations should remind staff to wear ID at all times whilst on-site, and to actively challenge anyone who is not and/or unfamiliar faces, particularly individuals in sensitive areas or around any store rooms containing vital equipment or supplies.	None	None	Audit Committee	None	Significant	1	2	2
SO1-035	**Emergency Planning Resilience Response (EPRR) Process**	Strategic Objective 1: To be high performing, deliver our statutory duties and use our available resources innovatively to deliver the best outcomes for our population	IF the EPRR delivery plans are not maintained and updated as is it's legal duty under the Civil Contingency Act. THEN the CCG would not be meeting its legal duty and may fail to open to manage any emergency situations.	Nadia Baig/ Shaju Ahmed	1	4	4	1. The CCG fulfils its duties and requirements. The CCG has an incident response plan in place and emergency response plans in place. We also have a 24/7 on call rota to deal with any incidents affecting the HMR locality. The D.PH. chairs the HERG. 2. Maintain 100% compliance with EPRR Standards	Further revision in next year as part of integrated system development	None	Health Economy Resilience Group (HERG) NES Group Local Health Resilience Panel (LHRP) - GM Wide	Future plans as part of integrated working across GM and HMR	Significant	1	2	2

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SO1-003	**Recruitment Frauds**	Strategic Objective 1: To be high performing, deliver our statutory duties and use our available resources innovatively to deliver the best outcomes for our population	IF robust pre-employment checks are not being completed due to the capacity issues OR organisations fraudulently submit staff reimbursements THEN there will be unqualified staff operating in the locality posing risks to residents and a negative financial impact on the funding organisation.	Damien Heakin/ Jonathan Evans	2	2	4	1 Candidates are notified of the seriousness of misrepresentation of qualifications, skills and experience that have prompted NHS organisations' to review their pre-employment screening checks. 2. Policies are in place to fully check individuals qualifications and service where they already work in the NHS. 3. Manager spot checks to ensure that additional staff being paid are actually in post and undertaking the work required 4. Checks to ensure that additional staff deployed are appropriately qualified for the position they are filling 5. Checks to ensure that invoice / payment activity matches against shifts booked / worked 6. Checks to ensure that the shifts / work that has been commissioned have actually been completed (checks on timesheets / rotas) 7. ID checks, or necessary assurances from agencies, to confirm that individuals are who they claim to be / have a tight to work / and are not a threat to staff or patients 8. Local risk assessments around recruitment / appointment in accordance with the role and nature of the work undertaken by the relevant individuals.	None	None	Finance, Performance and Risk Governing Body.	None	Significant	1	2	2
SO1-028	**Equality Objectives**	Strategic Objective 1: To be high performing, deliver our statutory duties and use our available resources innovatively to deliver the best outcomes for our population	IF the CCG fails to deliver the Equality Objectives THEN there is a risk that the CCG breach legislation	Samina Arfan	2	2	4	1. The CCG and Local Authority developed and published joint equality and inclusion strategy with RMBC which defines five joint Equality Objectives to work towards for the next 3 years. 2. An eighteen month review has been undertaken as part of the Public Sector Equality Report which was endorsed by GB 21/01/2022	Implementation against these objectives and annual progress reports	Haven't received any guidance for the 2022 NHS Workforce Race Equality Standard and the deadline is August.	Quarterly update reports to: Quality and Safeguarding Committee; PPEC; Joint Equality Steering Group: Leadership, NHS England	None	Significant	1	1	1
SO1-030	**Failure to Respond to Complaints**	Strategic Objective 1: To be high performing, deliver our statutory duties and use our available resources innovatively to deliver the best outcomes for our population	IF the CCG fails to respond to complaints, concerns, compliments and MP letters THEN it will not fulfil its statutory duties and may face external scrutiny from the public, media, MPs and regulatory bodies, such as the Parliamentary and Health Service Ombudsman.	Rob McDougall	1	3	3	1. Regular quarterly reporting to the CCGs Quality and Safeguarding Committee and PPEC with attendance by the Head of Patient and Corporate Services to present the reports and answer any questions that are raised. 2. Complaints continue to be managed as per the individual arrangements that are agreed with each complainant and in accordance with National regulations. 3. Notification of all new cases received are shared with the respective CCG team/Staff members, including the escalation of any and all safeguarding and serious concerns.	In the event that a provider organisation does not provide information as a part of a commissioner-led investigation, this will be escalated, initially within the provider organisation and then, if necessary, with the support of Quality and Safeguarding and commissioning colleagues. Complainants are kept informed throughout the investigation process.	Investigation responses not being received from provider organisations within the required timescale, preventing the CCG from responding to the issues raised within the agreed time period.	Quality & Safeguarding Committee, Patient and Public Engagement Committee (PPEC)	None	Significant	1	1	1
SO1-060	**EDS 2 (Equality Delivery System 2)**	Strategic Objective 1: To be high performing, deliver our statutory duties and use our available resources innovatively to deliver the best outcomes for our population	IF providers within the system fail to deliver Equality Delivery System (EDS) 2, THEN the CCG/ICB would be in breach of an NHSE mandatory programme of work, leading to possible sanctions from NHSE and possible adverse media coverage.	Samina Arfan	1	2	2	Since the Last EDS grading in late 2018 the CCG has been working on a joint apprach with RBC. Due to capacity and the Covid period the public sector report provided the work done against the Joint CCG and RBC Equality objectives which align with EDS 2. A formal grading event has not taken place with local stakeholders. This has coincided with NHS England's webinar for their new reviewed EDS which has 3 domains. Given where we are with transition this will now be built into the new placed based structures because going forward the ICB will be responsible to do EDS but evidence will be gathered from localities.	To be reviewed as the CCG becomes part of the new ICB	None	Quality and Safeguarding Committee; PPEC; Joint Equality Steering Group: Leadership, NHS England	None	Significant	1	1	1