Buckinghamshire CCG-CORPORATE RISK REGISTER: AUGUST 2021 COVID-19 (High Level Risks extract)

Risk Title	Risk Causes	Risk Description (IF)	Risk Effect (THEN)	Consequence (LEADING TO)	Risk Owner	Delegated Risk Owner	Corporate Risk Owner	Risk Baseline Score	Risk Score After Mitigation	Corporate Risk Score	Risk Score target (what is the aim)	Reasoning for Current Score	Reasoning for Target Score	Risk Proximity	Controls & Assessments in Place	Actions Required	CROSS REFERENCE TO OTHER COVID-19 RISK REGISTERS: Integrated Care Partnership June 2020	CROSS REFERENCE TO OTHER COVID-19 RISK REGISTERS: Integrated Care Partnership April 2021
EXISTING RISKS AT OR ABOVE ESCALATION THRESHOLD FOR CORPORATE RISK SCORE (12+)																		
PATIENT PATHWAYS																		
1. Increased Non Elective short stay activity	Increase in non-elective activity across all providers especially with regard to short stay admissions. Emergence of Covid-19 (coronavirus) which could be a further contributory factor to increased Non Elective short stay activity through increasing number of cases.	The CCG is unable to address the identified growth in Non Elective activity	Then we will have PbR over-performance on some contracts and may be unable to deliver QIPP saving targets for 18/19.	Leading to a follow on impact for 2019/20 QIPP targets. The quality, safety and patient experience will be negatively impacted in relation to the appropriateness of short stay admissions, especially for those of less than 1 hours duration.	**Dr Dai Sahota**	**Nicola Newstone**	**Robert Majilton**	20 (5*4)	16 (4*4)	16 (4*4)	4 (2*2)	Activity levels to date in year this financial year have shown no decrease on 17/18 baselines; The financial risk has not changed. However, the national direction of travel is Same Day Emergency Care (SDEC) and this is being considered with contracting. We are also in the process of reviewing and updating the wording of this risk. February 2020 update: Risk score unchanged as a result of Covid-19, but this risk updated to reflect there could be an increase in the number of cases emerging across the county, rather than developing a wholly separate risk on this matter, given the overall risk to the population is low. March 2021: risk paused whilst Risk paused due to changes in the financial regime whilst the pandemic continues. To be reviewed again for 2021/2022. A separate risk register addresses pandemic specific risks.	BAU restored post pandemic	Immediate	**CONTROLS:** 1. Ongoing analysis of Non elective activity to identify themes and trends. 2. The BCCG Associate Director Contracts and Performance- attends Contracts Performance meetings and Finance activity meetings for Frimley NHSFT. 3. NEL Delivery Group is in place with specific programme of work, providing weekly reporting to facilitate timely responsiveness to actions and data reported. 4. South Bucks Facing project in place to support delivery of agreed actions in relation to the non elective demand management work. 5. Specific contingency measures through Buckinghamshire Healthcare NHS Trust regarding Covid-19 in line with national guidance issued by NHS Emergency Preparedness Resilience and Response. Covid-19 communications: https://www.buckinghamshireccg.nhs.uk/coronavirus-covid-19-latest-information-and-advice/. Buckinghamshire Healthcare NHS Trust also have their own contingency measures in place: https://www.buckshealthcare.nhs.uk/About/public-information-about-covid-19-coronavirus.htm 6. CCG Business Continuity Plan into effect where there is an impact on CCG staff resulting from potential for school closures in line with government action taken. **ASSURANCES:** 1. Contract Management - weekly reporting from NEL Delivery Group. 2. Clinical Management - a number of committees discusses the controls and assurances to mitigate this risk through standing items. 3. South Facing Bucks group who regularly review and update work streams and associated actions to ripport delivery of programme. This is now part of the system wide urgent care group meeting. 4. Daily sit reps through hospital operations and CCG director on call. 5. Business Continuity Plan monitoring though senior management and other team meetings (face to face or virtual as the need arises)	1. Transformation work streams to strengthen significant system change to impact on performance and activity. 2. Roll out of Same Day Emergency Care (SDEC) within the BHT and ensuring links to neighbouring trusts to improve flow and activity. 3. Reformatting of A&E Delivery Board to have stronger focus on change that will have a direct impact on activity. 4. Roll out requirements of the NHS Long Term Plan. Owner: Urgent and Emergency Care Director, timescale: ongoing Ongoing monitoring of Covid-19 impact. Owner - Catherine Mountford, Accountable Emergency Officer	18. Community Hospitals currently not taking step down asymptomatic patients who have not been tested prior to discharge. This is causing specific issues relating to discharge. 32. Increase in non-elective activity across all providers especially with regard to short stay admissions.	18. Community Hospitals currently not taking step down asymptomatic patients who have not been tested prior to discharge. This is causing specific issues relating to discharge. 32. Increase in non-elective activity across all providers especially with regard to short stay admissions.
2. Cancer management during COVID-19 outbreak	National guidance [through NHS Digital] is that several people will not have chemo due to risk and staffing capacity aligned to ongoing COVID-19 pandemic. Nationally surgeons will not be operating immediately on early stage cancers, again for risk and capacity reasons.	Further 2WW first appointments are cancelled during the duration of the COVID-19 pandemic (for as long as it lasts which is currently unpredictable).	Two week wait target of 93% will further deteriorate. And staging of cancer for patients may be later resulting in complexity of tumour. Furthermore, patients do not present to services with symptoms.	(1) Longer patient waiting times (2) patients are not presenting to primary care early enough which will lead to late presentations. (3) exacerbation of condition where suspect cancers are not caught early. (4) increased burden on acute cancer services and surgical capacity (5) increased demand on tertiary services (6) Poorer outcomes for patients	**Robert Majilton**	**Dr Raj Thakkar**	**Robert Majilton**	25 (5*5)	16 (4*4)	16 (4*4)	4 (2*2)	December 2020: cancer treatment capacity not reduced. Triggers live and ready to enact but not yet required. current service levels being maintained. Remains at 16 to maintain Governing Body visibility. Risk anticipated to reduce if COVID-19 surge subsides. March 2021: referrals and admissions known to have reduced during the pandemic compared to non-covid levels, which means an expected increase in activity once normal business resumes. However capacity and diagnostics have remained available where needed for urgent priority referrals. Priority to patients with highest clinical need and priority. **April 2021: planning requirements led to draft aims for 2021/22, to be fleshed out once planning submission confirmed. Recovery group and workstreams to be subsequently mobilised to deliver.**	BAU restored post pandemic	Immediate	**CONTROLS:** 1. Ongoing assurance calls with NHS England. 2. Advice and guidance circulating to practices 3. Tumour pathway guidance published https://www.rcr.ac.uk/college/coronavirus-covid-19-what-rcr-doing/coronavirus-covid-19-resources/coronavirus-covid-19-1. **ASSURANCES:** 1. Assurances to CCG Executive Committee through Corporate Risk Register and CCG Cancer Strategy Group 2. Issues discussed at TV alliance meeting [as our issues are not unique] 3. Tumour pathway guidance: this issue is being raised through gold command. 4. Assurance request from Trusts: a. What can be done/mitigation b. Tracking process c. Harm reviews: Buckinghamshire Healthcare NHS Trust especially tracking affected patients (by name) and complating clinical harm reviews. d. How trusts are risk-stratifying e. Comms strategy. f. Sought to ensure cancer and elective care pathways and available capacity (from providers both local and tertiary) are clear in order to inform patients accordingly. 4. Monitoring of risk through Clinical Harms Group	Description of mitigating actions as otherwise described within Restoration and Recovery Highlight report. As with action for restoration and recovery	**Restoration and Recovery Board Risk Register** *Non-delivery of activity trajectories may result in longer waits (inc 52 week breaches), clinical safety issues and possible harm to patients. It may also means system financial penalties* *Second Surge of COVID 19 leading to shut down of services , lack of staff and increased waits / service deficiencies*	**Restoration and Recovery Board Risk Register** *Non-delivery of activity trajectories may result in longer waits (inc 52 week breaches), clinical safety issues and possible harm to patients. It may also means system financial penalties* *Second Surge of COVID 19 leading to shut down of services , lack of staff and increased waits / service deficiencies*
3. Management of RTT first outpatient appointments during COVID-19 outbreak	Cancellation of RTT 18 week first outpatient appointments and outpatient follow up in light of staffing capacity release to manage COVID-19 outbreak. RTT national targets not met. Routine referrals stopped during pandemic. Community providers have reduced services and in some cases suspended them due to COVID risks	Further first outpatient appointments are cancelled during the duration of the COVID-19 pandemic (for as long as it lasts which is currently unpredictable).	National Target: 92% Operating Plan trajectory: 90.9% for RTT – Incomplete pathways (patients to start treatment within a maximum of 18 weeks) will further deteriorate. Furthermore, suspension of services is compounding support for those in the community that are not high risk but would otherwise have had ongoing care.	1. Longer patient waiting times; Furthermore, suspension of services is compounding support for those in the community that are not high risk but would otherwise have had ongoing care. 2. Potential for legal challenge as to interpretation of guidance, timing of intervention and organisational accountability. 3. Health inequalities in deprived communities as well as: 4. More severe and complex presentations in morbidity due to late presentation for treatment 5. Increased and unnecessary mortality rates 6. exacerbations in conditions where illness was not identified early. 7. Poorer outcomes for patients not understanding the increased risks posed to them of not seeking medical advice 8. Longer patient waiting times/capacity pressures when primary care services resume BAU	**Robert Majilton**	**Dr Raj Thakkar**	**Robert Majilton**	25 (5*5)	16 (4*3)	16 (4*4)	4 (2*2)	Risk score remains high whilst assurances on controls sought from NHS Digital (routine ERS patients cannot be sent reminders). Feedback from primary and secondary care has highlighted fewer presentations by patients. Community providers have reduced capacity (and access) December 2020: RTT revised trajectory to manage capacity and waiting list under control in line with phase 3 planning submission and is improving overall. Risk Score remains at 16 to maintain Governing Body visibility. Risk anticipated to reduce if COVID-19 surge subsides. March 2021: referrals and admissions known to have reduced during the pandemic compared to non-covid levels, which means an expected increase in activity once normal business resumes. However capacity and diagnostics have remained available where needed for urgent priority referrals. Priority to patients with highest clinical need and priority. **April 2021: planning requirements led to draft aims for 2021/22, to be fleshed out once planning submission confirmed. Recovery group and workstreams to be subsequently mobilised to deliver.**	BAU restored post pandemic	Immediate	CONTROLS: 1. Clarity from NHSD on how they expect Trusts to manage this during the pandemic, to include such measures as: 2. If it is a first OPD they should offer another appointment as now UNLESS they have a robust channel that patients can call and re book themselves at a safer point in time in the future. They don't have this at the moment patients are not getting through to re book or cancel. They cannot just choose to discharge prematurely discharge back to primary care. 3. Offering advice and guidance service to patients through Buckinghamshire Healthcare NHS Trust. 4. Communications developed with providers and colleagues in BOx remind patients to still contact services if they have urgent requirements. 5. CCG to support and engage in recovery planning to support whole system consideration and development to support patients and capacity from providers - learning and maintaining positive changes as well as developing future commissioning beyond COVID-19 **ASSURANCES:** 1. Assurances to CCG Executive Committee through Corporate Risk Register 2. Reporting through the Thames Valley Cancer Alliance 3. Monitoring of risk through Clinical Harms Group	Description of mitigating actions as otherwise described within Restoration and Recovery Highlight report. As with action for restoration and recovery Identification of current RTT impact to inform next phase of recovery planning by end of March 2021 led by Planned Care.	**Restoration and Recovery Board Risk Register** *Non-delivery of activity trajectories may result in longer waits (inc 52 week breaches), clinical safety issues and possible harm to patients. It may also means system financial penalties* *Second Surge of COVID 19 leading to shut down of services , lack of staff and increased waits / service deficiencies*	**Restoration and Recovery Board Risk Register** *Non-delivery of activity trajectories may result in longer waits (inc 52 week breaches), clinical safety issues and possible harm to patients. It may also means system financial penalties* *Second Surge of COVID 19 leading to shut down of services , lack of staff and increased waits / service deficiencies*
4. Timely presentation for adults and children with non-COVID-19 related conditions	Patients (adults with long term conditions, and/or mental health and/or learning disabilities) are not presenting in primary care or outpatients as a result of fear of infection due to pandemic. There is a clinical concern that: 1. there will be a huge demand spike once lockdown released. 2. this will put significant pressure on primary and secondary care. 3. we will see late stage presentations of cancer and other diseases.	patients are not presenting in primary care or outpatients, or parents are not bringing their children, for fear of infection	non-COVID-19 condition could unnecessarily exacerbate	1. severe harm or death from long term condition other than COVID-19. 2. Potential for legal challenge as to interpretation of guidance, timing of intervention and organisational accountability. 3. Health inequalities in deprived communities as well as: 4. More severe and complex presentations in morbidity due to late presentation for treatment 5. Increased and unnecessary mortality rates 6. exacerbations in conditions where illness was not identified early. 7. Poorer outcomes for patients not understanding the increased risks posed to them of not seeking medical advice 8. Longer patient waiting times/capacity pressures when primary care services resume BAU	**Dr Dai Sahota**	**Dr Juliet Sutton**	**Robert Majilton**	25 (5*5)	12 (4*3)	12 (4*3)	4 (2*2)	The risk score remains high until control and assurance work as described has been complete. November 2020: Second wave and surge planning in place, which includes triggers to understand and escalate further risk as the situation evolves. December 2020: risk unchanged. March 2021: risk unchanged **April 2021: planning requirements led to draft aims for 2021/22, to be fleshed out once planning submission confirmed. Recovery group and work streams to be subsequently mobilised to deliver.** **Hot hub not in high use so offers additional availability. Risk score recommended as reduced to 12. Adequate resource within hot hubs to meet current demand - primary care well aware of pathway options.**	BAU restored post pandemic	Immediate	**CONTROLS:** 1. System mitigation plan, including developing an SOP for the clinical harm process (using London Clinical Senate equivalent document as a benchmark). 2. Separate Group across ICP to be convened "Clinical Harm through delayed access to Treatment" (NON COVID-19 patients)", with purpose to map the harms in a coordinated way, and 2; our response to these, we may need to work differently in terms of how we respond and share information. 3. Population risk stratification/risk profiling (shielded patient list -see separate risk). 4. Deployment of information as resources through media and primary care (Team Net), such as: a. https://www.rcpch.ac.uk/sites/default/files/2020-04/covid19_advice_for_parents_when_child_unwell_or_injured_poster.pdf b. practices remain open; telephone triage and advice and guidance with links to AskNHS app. 5. Risk assessment and assurances on provider processes (whilst shielded patient profiling continues): each specially needs to risk stratify their patients. 6. Long Term conditions team supporting messaging through MJOG with advice for patients on how to look after themselves. 7. Revised comms strategy to tackle health inequalities in the community - development of improved and ongoing, targeted comms (programmes in conjunction with ICP partners (comms and Public Health teams BCC/BHT) with key message indicating that Primary Care is open and how to access services and for targeted health programmes/messages. Best practice to be replicated from 2020 Ramadan project: where advice and guidance on supporting the Muslim community to manage covid19 risks during Ramadan was communicated with the assistance of primary care, faith/community/voluntary groups to distribute to the community using different media formats e.g. WhatsApp , video, PC covid19 bulletin and teamnet page to support communication and reach of messages/programmes. **ASSURANCES:** 1. Reporting through this Register and Clinical Harm Group 2. Escalation to Quality and Performance Committee where necessary. 3. COVID-19 chief executives group 3 times per week (Monday, Wednesday, Friday 8am) for escalated issues. 4. Inequalities issues to be discussed at EDI group to develop an ICP approach (BCC, PH, BHT) to widen reach of messages to targeted communities	Non specific actions identified as there are no specific mitigations - these are covered under other risks to make sure priority referrals are addressed.	14. Increasing demand and exacerbated MH presentations across service providers directly relating to Covid-19 22. Patients (including children) are not presenting in general practice / hospital settings with non Covid ailments which could be seen and dealt with before they escalate	14. Increasing demand and exacerbated MH presentations across service providers directly relating to Covid-19 20. Renal therapy is an issue and a solution is being looked at. 22. Patients (including children) are not presenting in general practice / hospital settings with non Covid ailments which could be seen and dealt with before they escalate
5. Restoration and Recovery	Recognition that there are concerns among providers and patients about arrangements for restoration and recovery of a range of services, specifically those as BAU and not just those with highest clinical risk (i.e. COVID-19 risks 2 cancer, 3 RTT and 4 timely presentation adults and children. NHS England phase 3 plan expectations - by Christmas we are expected to restore services to similar levels of capacity as at same point in time as 2019/2020.	BAU is not restored and recovered as is appropriate for population needs (Non-delivery of activity trajectories)	targets, objectives and key performance indicators of individual service specifications will not be met	1. Longer patient waiting times 2. Poor patient experience 3. Premature discharge back to primary care 4. Need for re-referral from primary care 5. A potential wave of activity as when referrals are opened again that may put pressure on capacity. 6. system financial penalties. 7. Non-compliance with phase 3 requirements with national deadline may result in additional scrutiny of the Buckinghamshire ICP 8. Increase in 52 week breaches	**Dr Raj Thakkar**	**Neil Flint** **Nicola Newstone**	**Robert Majilton**	20 (5x4)	16 (4*4)	12 (4*3)	8 (2*4)	October 2020: funding now in place to close gap on trajectories, which contributes to mitigations. Was previously scored higher but now remains at 12. The full amount of funding may not be realised. November 2020: Second wave and surge planning in place, which includes triggers to understand and escalate further risk as the situation evolves. December 2020: risk management evidence described within the R&R highlight report March 2021: highlight report not supplied since December 2020 due to increased pandemic activity and surge response. **April 2021: planning requirements led to draft aims for 2021/22, to be fleshed out once planning submission confirmed. Recovery group and work streams to be subsequently mobilised to deliver.**	Considerable time expected before recovery to pre-pandemic operation, therefore some residual risk is tolerated	Immediate	**CONTROLS:** 1. Restoration and Recovery planning - clarifying planned care arrangements to understand which services are likely to come back online. 2. sharing the harms information to inform the High Impact Assessment by Public Health at the Council. 3. awating additional guidance from NHSE/I and discussions are occurring at a BOB ICS level around priority setting. **ASSURANCES:** 1. Reporting on Restoration and Recovery planning through CCG Executive Committee and CCG Governing Body standing items. 2. Separate ICP risk register covering arrangements and further details in urgent and emergency care 3. Recovery and Renewal programme Monthly Highlight Report; circulated to Recovery and Renewal Board, through BHT Executive Management Committee, CVCG Executive, CCG Governing Body, ICP Partnership Board. This report also covers risks which have been cross referenced to this Risk Register. This report breaks down this risk into its component parts. 4. Risk and Monthly Highlight Report cross referenced after the Recovery and Renewal Board has met on first Monday of the month	Recovery and Renewal programme Monthly Highlight Report to be re-instated by end of March by Neil Flint, with new restoration and recovery plan to reflect phase 4 priorities identified by regulators	**Restoration and Recovery Board Risk Register** *Non-compliance with phase 3 requirements with national deadline may result in additional scrutiny of the Buckinghamshire ICP* *Failure to provide correct weekly national reporting data can result in reputational damage to the trust and system*	**Restoration and Recovery Board Risk Register** *Non-compliance with phase 3 requirements with national deadline may result in additional scrutiny of the Buckinghamshire ICP* *Failure to provide correct weekly national reporting data can result in reputational damage to the trust and system*
CCG FINANCES																		

Buckinghamshire CCG-CORPORATE RISK REGISTER: AUGUST 2021 COVID-19 (High Level Risks extract)

																CROSS REFERENCE TO OTHER COVID-19 RISK REGISTERS	
Risk Title	Risk Causes	Risk Description (IF)	Risk Effect (THEN)	Consequence (LEADING TO)	Risk Owner	Delegated Risk Owner	Corporate Risk Owner	Risk Baseline Score	Risk Score After Mitigation	Corporate Risk Score	Risk Score target (what is the aim)	Reasoning for Current Score	Reasoning for Target Score	Risk Proximity	Controls & Assurances in Place	Actions Required	Integrated Care Partnership June 2020	Integrated Care Partnership April 2021
6. Impact on operating plan targets	CCG required to make annual operating plan submissions to NHS England.	CCG unable to meet financial targets as specified within operational planning submission to NHS England of 5 March 2020 or requirements under new finance mandated regime once published Guidance suggests break even position to be held by the CCG with national top up methodology to facilitate this, however, there may be a risk that this will not completely fund overspend variances	the CCG would not meet its full year financial control total	1. non-compliance with statutory responsibilities 2. non-receipt of Commissioning Sustainability Fund (CSF) monies from NHS England 3. Implications for ICP system control total 4. Impact on planning a balanced outturn for future years 5. Potential for special measures	**Kate Holmes**	**Kate Holmes** **Alan Cadman**	**Kate Holmes**	**25 (5*5)**	**16 (4*4)**	**16 (4*4)**	**4 (2*2)**	25/08/2020 - moderated corporate risk score at 16 by CCG Executive Committee September 2020: Risk and score has remained unchanged since this time Operating Plan targets effectively paused while in COVID-19, superseded by recovery targets under restoration and recovery risk October 2020: Recovery planning in line with phase 3 submission, however wave 2 may change this and impact on ability to deliver March 2021: Full year financial control total may be met given pandemic impact. To be confirmed as part end of financial closure - risk remains open until then. April 2021: remains the same until completed year end and audit, pre-audit surplus of £139k. **May 2021: as above - awaiting year end audit**	Full year financial control total may be met given pandemic impact, therefore some residual risk is tolerated	Immediate	**CONTROLS:** 1. Monitor and report existing and future plans against 5 March submissions. 2. Full re-forecasts to follow: a. Impact of block contract arrangements if extended to financial year-end b. Non-delivery of QIPP savings given costs arising from COVID-19 c. Impact of missed ICP/ICS savings targets **ASSURANCES:** 1. Monthly reporting through CCG Finance Committee and to Governing Body on escalation.	None specific	n/a - CCG only risk	n/a - CCG only risk
7. Financial impact due to increased COVID-19 costs	Wider financial impact of increased costs due to changes in delivery of some services due to the covid 19 pandemic. Direct costs are due to be reimbursed directly from central NHSE funding, however, required changes due to covid 19 may lead to wider financial impact across the CCG spend.	- There is a change in required provision of services or ways that services are provided resulting from the impact of the covid-19 pandemic - A short supply of prescription drugs in primary care resulting from increased demand due to COVID-19. Specifically: 1. lorazepam (and/or other end of life drugs) 2. diamorphine	CCG could experience increase in costs resulting from these required service provision changes and increased prescribing of branded products and/or more expensive alternatives, which is beyond cost increases associated with No Cheaper Stock Obtainable (NCSO)	1. CCG unable to meet financial targets as specified within operational planning submission to NHS England of 5 March 2020 (which also forms final submission due to pause in process)1. the CCG would not meet its full year financial control total 2. non-compliance with statutory responsibilities 3. non-receipt of Commissioning Sustainability Fund (CSF) monies from NHS England 4. Implications for ICP system control total 5. Impact on planning a balanced outturn for future years 6. Potential for special measures	**Kate Holmes**	**Kate Holmes** **Alan Cadman**	**Kate Holmes**	**25 (5*5)**	**12 (4*3)**	**12 (4*3)**	**4 (2*2)**	25/08/2020 - moderated corporate risk score at 12 by CCG Executive Committee September 2020: Risk and score has remained unchanged since this time. Risk could be downgraded, however Head of Governance deemed risk to remain at 12 to prompt re-review if there is a second surge and increase in drug demand. October 2020: second surge planning underway for imminent impact - risk remains the same. Surge plans approved through various forums, including Finance Committee, and STW for additional D2A beds at Chesham Leys (Specialist nursing care for older people in Buckinghamshire run by the Freemantle Trust). March 2021: Full year financial control total may be met given pandemic impact. To be confirmed as part end of financial closure - risk remains open until then and future funding source confirmed. April 2021: remains the same until completed year end and audit, pre-audit surplus £139k. **May 2021: as above - awaiting year end audit**	Surge plans remain on place – increased costs from hospital discharge programme still to be mitigated with funding source (April/May). Though costs expected to be covered as with above	Immediate	**CONTROLS:** 1. Monitor and report existing and future plans against 5 March submissions. 2. Full re-forecasts to follow: a. Impact of block contract arrangements if extended to financial year-end b. Non-delivery of QIPP savings given costs arising from COVID-19 c. Impact of missed ICP/ICS savings targets **ASSURANCES:** 1. Monthly reporting through CCG Finance Committee and to Governing Body on escalation.	None specific	n/a - CCG only risk	n/a - CCG only risk
8. "Reasonable" costs associated with COVID-19	The letter from NHSEI (dated 17/03/2020) regarding 'Next Steps on NHS Response to COVID-19' made a clear commitment that additional funding will be provided to cover the costs of responding to the coronavirus emergency. https://www.england.nhs.uk/coronavirus/publication/next-steps-on-nhs-response-to-covid-19-letter-from-simon-stevens-and-amanda-pritchard/	reasonable costs associated with COVID-19 are not clearly controlled, documented and reported	financial control and stewardship of public funds could be called into question	1. potential for investigation into financial mismanagement 2. reputational damage arising as a result of the above	**Kate Holmes**	**Kate Holmes**	**Kate Holmes**	**15 (5*3)**	**8 (4*2)**	**N/A**	**8 (4*2)**	Although there is no evidence of reasonable costs being above expected levels. March 2020 return to NHS England included £1.8m additional COVID-19 related costs for the CCG, and £9.8m for Buckinghamshire Healthcare NHS Trust - cumulative figure £11.5m.Claim made for 19/20 has been covered in full by an allocation received 17/04/2020 April 2020 submission: £1.7m for April. £1m hospital discharge. £250,000k costs associated with primary care practices opening over the bank holiday weekend. Need to tighten up GP claims for May as they have been variable. May 2020: claim of £1.8m, full detail reported to CCG Finance Committee 24 June 2020. March 2021: funding in place until year-end. MT-12 in baseline. Only reclaim is hospital discharge with funding Month 11 up to 80% of forecast figure. **April 2021: This is now 100%, and all funding received for 2020/2021. Going forward hospital discharge to be funded on reimbursable process - 6 weeks for first three months, reduced to 4 weeks for following three months. To be reviewed and proposed for closure subject to year-end audit** **May 2021: as above**	Pandemic over and additional cost pressure subsides	Immediate	**CONTROLS:** 1. Standard Operating Procedure to set out the CCG's arrangements to meet the requirements of NHS England's letter. It seeks to enable the CCG to make expedient decisions to respond effectively to the current emergency situation, whilst still adhering to appropriate financial governance (endorsed by CCG Finance Committee 01/04/2020, approved by CCG Governing Body member 01/02 April 2020 through constitution emergency decisions clause). This includes appropriate temporary amendments to the CCG scheme of reservation and delegation. 2. Costs will be collated on a monthly basis and signed off by the CCG Chief Finance Officer prior to submission to NHS England. 3. A procedure note has been defined to set out the requirements for all staff in capturing COVID-19 expenditure. This has been communicated to all staff. 4. This SOP also documents and the claim form to be used by primary care member practices for the same purpose, with each claim form reviewed by the CCG Finance Team. **ASSURANCES:** 1. Nominated staff in Finance have been assigned to manage this, with appropriate business continuity measures in place. 2. All requests and approvals will be formally reported to the CCG Finance Committee and will inform a monthly return to NHS England. This will be regularly shared with SMT for visibility. 3. Buckinghamshire Healthcare NHS Trust have an equivalent SOP: https://www.buckshealthcare.nhs.uk/Downloads/AA_COVID_19/COVID-19_STAFF%20INFO/FINANCE/200406_BHT%20SOP%20Financial%20Governance%20Covid-19%20FINAL%20v1.0%20APPROVED.pdf	None aside from implementation of approved Standard Operating Procedure (SOP) as described	n/a - CCG only risk	n/a - CCG only risk
30. Prescribing growth	NHS England is responsible for determining allocations of financial resources to Clinical Commissioning Groups (CCGs). Total annual budgets given to CCGs cover the majority of NHS spending. As part of the new financial regime, the CCG has been given an allocation for prescribing which is a rate of 1.5% growth in 2020-2021 (which does not include MFF - Market Forces Factor (MFF) to all services except for prescribing, as this is not affected by geographical cost differences).	The CCG does not receive national funding (additional growth to allocation) to cover increased costs associated with prescribing by the end of the financial year 2020/21.	financial risk of cost pressures relating to: 1. Prescribing growth as a whole (price impact and volume impact) 2. Any additional risk relating to Category M or NCSO	(a) inability for the CCG to meet its control total (b) impact on wider ICS control total (c) Potential for section 30 (Local Audit and Accountability Act 2014 and National Health Service Act 2006) letter to Secretary of State.	**Kate Holmes**	**Alan Cadman** **Kate Holmes**	**Kate Holmes**	**16 (4*4)**	**16 (4*4)**	**16 (4*4)**	**8 (2*4)**	Data two months in arrears. It is difficult at this stage to know if a longer term impact of this increase will be felt during the rest of the financial year (likely to the tune of several million pounds) 22/06/2020: Month 3 data received - 10% growth M1, then -8% month 2, then 10% month 3. 7.5% growth project for rest of financial year. October 2020: 8.6% growth included in CCG MT-12 plan, which remains above 1.58% growth allocation received within phase 3 plan. Plan to re-start Optum to review switching in primary care practices paused due to Wave 2. March 2021: difference between growth and funding reported in October remains the same. To be mitigated only through other budget underspends to meet deficit target. Optum status unchanged. **April 2021: remains unchanged. Budget changed to reflect 8.8% actual growth and come into on budget (as part of £139k surplus). Risk remains for 2021/2022, 9.68% growth allocated which is likely to be exceeded.** **May 2021: as above**	Growth likely to continue to exceed central funding, therefore some residual risk is tolerated	Immediate	**Controls and mitigations:** (1) careful monitoring of the risk through the Finance team (2) Escalation to regional team (3) escalation to Finance Committee, Executive Committee and Governing Body (4) Planning for re-start of efficiencies and looking at options to re-engage Optum to review switching in primary care practices. **Assurances:** (1) Finance Committee risk register (2) Finance Committee, Executive Committee and Governing Body minutes	Continued close monitoring of prescribing of financial data Owner - Finance Team, timescale - monthly review Continued escalation to regional team if pressure continues. Owner - Finance Team, timescale - monthly review A deep dive is currently taking place to understand the drivers of prescribing growth. Owner - Finance Team, timescale - monthly review		
31. Re-imbursement of COVID-19 costs by NHS England (separate to risk on control, documentation and reporting)	Although reasonable costs will be re-imbursed by NHS England: 1. Revenue - impact of COVID-19 related expenditure - the CCG may not be refunded in full for this. We have so far only been refunded for months 1 and 2 and may not be for remaining months. Also it is expected that phase 3 financial regime will provide a notional allocation for COVID expenditure for the rest of the financial year (at ICS level). This may not be adequate for the CCG to cover its costs. 2. Capital - the CCG purchased additional laptops back in April (quantity of 783 at value of £864k) to support primary care COVID-19 response. Funding from NHS England yet to be confirmed. The current expenditure has been offset against BAU capital which has created an in-year pressure.	The CCG does not receive full funding to re-emburse its COVID-19 costs, including: a) The element of the ICS Covid allocation assigned to the CCG is not sufficient to cover the Covid costs incurred in MT-12 b) The costs incurred under the Hospital Discharge Scheme 2 are not all reimbursed from NHSE	in-year financial pressure on capital and potential impact on statutory accounts (CCG directions)	(a) Reduction in future capital (b) Potential delays to projects which deliver the capital programme	**Kate Holmes**	**Alan Cadman** **Kate Holmes**	**Kate Holmes**	**16 (4*4)**	**16 (4*4)**	**16 (4*4)**	**4 (2*2)**	September 2020: Risk and score has remained unchanged since this time. COVID-19 related expenditure currently circa £3.1m a month, with estimate for remainder of the financial year to rise £3.3m. Retrospective allocations of £9.9m in respect of the Month 3 ytd position to achieve breakeven. This covers the COVID expenditure and CCG overspends. Further top ups have been agreed through the monthly assurance process with NHS England. The CCG is submitting monthly returns with all reasonable costs reimbursed through a robust governance process. October 2020: £3.6m within phase 3 month 7-12 plan for Bucks CCG from BOB COVID allocation. Expectation that CCG will manage within this position. This does not include wave 2 surge. March 2021: Full year financial control total may be met given pandemic impact. To be confirmed as part end of financial closure - risk remains open until then and future funding source confirmed. **April 2021: Going forward hospital discharge to be funded on reimbursable process - 6 weeks for first three months, reduced to 4 weeks for following three months. To be reviewed and proposed for closure subject to year-end audit.** **May 2021: as above**	Excess costs were fully reimbursed after wave 1 – unconfirmed but expected that this will occur again post second wave	Immediate	**Controls:** (1) careful monitoring of the risk through the Finance team (2) any further capital spend on hold and the Quality Impact Assessment of doing this needs to be completed (3) Continued escalation to regional team (4) escalation to Finance Committee, Executive Committee and Governing Body **Assurances:** (1) Finance Committee risk register (2) Finance Committee, Executive Committee and Governing Body minutes	Quality Impact Assessment of suspension of capital investment Owner - Balvinder Heran, timescale - September 2020. Balvinder has the template, this is in progress (18/09/2020)		
PRIMARY CARE **END OF LIFE AND FRAILTY**																		
30. Care Homes and COVID-19 testing (surge planning)	Discharge to Assess (D2A) aka hospital discharge programme is where people who are clinically optimised and do not require an acute hospital bed, but may still require care services are provided with short term, funded support to be discharged to their own home (where appropriate) or another community setting. Assessment for longer-term care and support needs is then undertaken in the most appropriate setting and at the right time for the person.New guidance has been received from NHSEI that said the CCG had to provide a surge capacity to accept negative COVID patients and a separate surge capacity for the few patients with a COVID positive swab. These risks therefore arise because: 1. A cohort of patients ready for discharge may have a positive COVID-19 test. 2. A whole of part of this cohort may still have symptoms. 3. Buckinghamshire has two care homes containing 8 Nursing and 9 residential beds from a total 70 D2A beds, but none which will accept people with dementia. 4. Where care homes do accept COVID-19 positive patients, there is a subsequent infection control risk to other residents to be mitigated. 5. A cohort of patients discharged will become temporally resident at a care home to meet their short term clinical needs. 6. This care home may be outside of the catchment for the GP practice with whom they are currently registered. 7. This care home may fall within a catchment for a different practice Of all the care homes , there is only a small number which are accepting COVID-19 positive patients. Further, were a legal claim to arise against a care home, a counter claim may arise whereby legal costs are sought against the CCG as the commissioner of the D2A pathway that facilitates discharge with a COVID-19 positive test.	Buckinghamshire Council are unable to commission sufficient care home bed capacity or alternatives to accept the number of patients being discharged from hospital on the D2A pathway who have a positive covid test result when ready for discharge	these patients will have to remain in hospital.	(1) Then acute hospital bed capacity may not be sufficient during a further Coronavirus surge leading to infected patients not being able to access the treatment they require. (2) The CCG would then need to commission additional acute bed capacity (3) Potential reputational damage. (4) infected patients not being able to access the treatment they require. (5) Cross infection for resident patients in care homes (6) Legal clinical negligence claims from care homes (7) counter claim against the CCG as the commissioner of the D2A pathway that facilitates discharge with a COVID-19 positive test	Kate Holmes	Ian Cave	Kate Holmes	**12 (4*3)**	**16 (4*4)**	**16 (4*4)**	**4 (2*2)**	Previously moderated at 16 to prompt visibility at Governing Body. New guidance has been received from NHSEI that said we had to have a surge capacity to accept negative COVID patients and a separate surge capacity for the few patients with a COVID positive swab. Chesham Leys/Freemantle Trust were approached, but Freemantle Trust have now withdrawn their offer. The CCG is now having to consider providing the COVID positive facility somewhere else. This creates a risk of COVID positive patients having to remain in hospital. We have a general increase in COVID patients and this risk captures that care homes who currently accept COVID negative patients may start to refuse to accept them and our current planning to mitigate this risk is to keep working with care homes that have worked with us in the past.	BAU restored post pandemic	Immediate	**Controls:** 1. Continue to commission as high a proportion of D2A care home capacity as possible which will accept people with a positive covid test. 3. Buckinghamshire Council to scope alternative options **Assurances:** reporting of the risk on the risk register	Scoping alternative options Owner - Ian Cave, timescale - ongoing	Not assessed	18. Community Hospitals currently not taking step down asymptomatic patients who have not been tested prior to discharge. This is causing specific issues relating to discharge. 27. New government guidance regarding the testing of patients being discharged into care homes will create challenges in the flow of discharges from the hospital to community capacity. Update 17/4: Where the homes do not have the facilities to isolate (particularly in complex cases) the onus falls back to the Local Authority and currently there is no place to fall back on. 28. Providers are struggling with nursing capacity and may not be able to staff their own care homes.

Buckinghamshire CCG-CORPORATE RISK REGISTER: AUGUST 2021 COVID-19 (High Level Risks extract)

																	CROSS REFERENCE TO OTHER COVID-19 RISK REGISTERS	
Risk Title	Risk Causes	Risk Description (IF)	Risk Effect (THEN)	Consequence (LEADING TO)	Risk Owner	Delegated Risk Owner	Corporate Risk Owner	Risk Baseline Score	Risk Score After Mitigation	Corporate Risk Score	Risk Score target (what is the aim)	Reasoning for Current Score	Reasoning for Target Score	Risk Proximity	Controls & Assurances in Place	Actions Required	Integrated Care Partnership June 2020	Integrated Care Partnership April 2021
31. D2A Care Home residents - medical intervention for temporary residents in care homes following hospital discharge		some GP Practices refuse to provide medical input to frail temporary care home residents admitted under the Discharge to Assess hospital discharge pathway	harm could arise e.g. due to not having their medication adjusted when required.	(1) Clinical harm to patients (2) additional cost pressure additional funding is required to provide the required medical input. (3) Reputational impact	Simon Kearey	Jessica Newman	Robert Majilton	16 (4*5)	16 (4*5)	12 (4*3)	4 (2*2)	Medical support to D2A temporary residents – The LMC are supportive for a temporary resident services in primary care and we are shortly going to put out communications to practices and PCNs about covering these temporary residents and how to do it whilst highlighting this is an appropriate thing for the PCNs to be doing. **March 2021: GP cover for temporary residents now being covered by PedBucks. Locally Commissioned Service in development for longer term management - but currently unclear as to expected sign up. Risk remains open qand scored at 12 until confirmed.**	Temporary resident status no longer required	Immediate	**Controls:** 1. CCG managers telephone these practices to ask for individual residents to be registered on a case by case basis. 2. work to clarify the exact clinical tasks required for these residents and the volume of workload - addressing registration, workload and pathway development. **Assurances:** 1. reporting of the risk on the risk register, 2. Minutes of discussions at Governing Body and other CCG meetings. 3. Care Homes raising concerns to commissioners.	Revised locally commissioned service for long term approach to be approved by PCCG by end of March 2021. Owner - Jessica Newman. Awaiting financial approval through CCG Finance Committee	Not assessed	31. Requirement to test all symptomatic and asymptomatic care home patients 33. If there is insufficient system co-ordination and support for Care Homes, then capacity, patient safety and the quality of care could be adversely affected
PROVIDER AND SYSTEM RESILIENCE																		
26. Local Outbreak Control / second wave preparation	Several waves of pandemic prompts comprehenseive local response measures	infection rates for coronavirus increase above threshold for high or very high	further lookdown restrictions come into effect	increased risk of related risks materialising	**Robert Majilton**	**David Williams** **Bashak Onal**	**Robert Majilton**	25 (5*5)	16 (4*)	16 (4*)	4 (2*2)	October 2020: risk score increased to 16 to reflect imminent second wave and launch of revised tiered levels for lockdown restrictions. Risk updated to reflect surge mitigations including surge plan. Buckinghamshire wide second wave surge plan noted by the CCG Executive Committee on 24 September 2020. CURRENT Local COVID alert level: medium RECOMMENDATION: This risk was not previously corporate risk scored. Now scored at 16 and should remain so to prompt escalation to Governing Body - to confirm that plans as described are in place and that the county's Tier level could increase if infection rates continue to rise. *Impact on CCG office arrangements described and moderated through a separate risk.* *Impact on pathways described and moderated through separate risks - cancer pathways, RTT, timely presentation for fear of catching the virus.* *October 2020: Executive Committee moderated at 16 to prompt Governing Body visibility* *March 2021: risk reviewed and remains at 16 whilst pandemic continues, not because the risk hasn't been largely mitigated as a local outbreak control plan remains in place. Health Protecfiion Board also includes multi-agency representation.*	Outbreak Control Plan stood down	Immediate	**CONTROLS:** 1. Local Outbreak Control Plan (previously developed, published and socialised.) 2. Buckinghamshire Covid-19 Second Surge Plan 3. Restoration and Recovery Programme Board activity also includes surge contingency planning **ASSURANCES:** 1. Discussion and Reporting through Buckinghamshire Health Protection Board with the CCG represented in its membership. This will take the necessary action to prevent, contain and manage outbreaks. 2. Discussion and reporting through Urgent and Emergency Care Board	Local Outbreak Control Plan: as identified and described within minutes and papers for the Health Protection Board. Surge Plan: As described within Recovery and Renewal programme Monthly Highlight Report and as identified through the Urgent and Emergency Care Board. No specific actions are required to mitigate the risk as the local plan is already in place.	None identified	None identified
CCG BUSINESS CONTINUITY AND STATUTORY DUTIES																		
20. Safeguarding statutory duties	Children and adults still require appropriate safeguarding arrangements whilst at risk from infection, as too are social workers visiting homes where individuals may be symptomatic.	Safeguarding Teams staffing, workforce redeployment issues and working arrangements are impacted by COVID-19.	CCG is unable to deliver Safeguarding Statutory duties (Adult and Child, Children in Care) .	1. breach of statutory duties 2. increased scrutiny from regulatory agencies	**David Williams**	**Gilly Attree**	**Robert Majilton**	25 (5*5)	12 (4*3)	12 (4*3)	4 (2*2)	25/06/2020 - moderated corporate risk score at 12 by CCG Executive Committee September 2020: risk remains unchanged November 2020: CURRENT DESIGNATED DOCTOR VACANCY; a gap in the statutory provision for a Designated Dr. Cross cover support from the Paediatric Team at BHT, unable to provide due to their own capacity issues. Cross cover from Berks West and Oxfordshire Designated Dr's will not compensate where there is a Buckinghamshire vacancy. 3 reliable agencies approached but unable to supply. paper to recruit to 2 additional safeguarding nurses was approved by the Joint Executive but due to ICS reconfiguration our restructuring of the team has been delayed, this provides additional capacity issues to manage the safeguarding arrangements for the CCG The Chair of the CDOP Panel left Bucks Council and the post as yet hasn't been replaced so in the interim the CCG Designated Nurse Safeguarding Children and Looked After Children as Deputy is providing cover, which also needs to be taken into account. March 2021: interim safeguarding adults lead permanent from 1 April 2021, Monday 8 March childrens safeguarding lead starts in post. May 2021: role still not filled with risk accepted - cover arrangements continue through other staff . Statutory requirement is per capita, therefore future abolition of CCGs and creation of single ICS body shall not reduce the number of roles required. Recruitment is proving tricky given the specific skills and experience necessarily and lack of suitability qualified candidates. Existing long term sick staff member is currently expected to return part time phased return from September 2021. **Update 28.06.21 - The CCG has confirmation that the Designated Doctor for Safeguarding Children and Looked After Children can return to work in a phased capacity as per the certified fit certificate**	Re-deployment ended and all statutory roles filled	Immediate	**CONTROLS:** 1. Shared risk management plans and BCPs to align across organisations and promote integration and mutual aid as necessary. 2. Close scrutiny and updates of policies and processes in line with emerging and updated legislation and guidance. 3. Cross cover from Berks West and Oxfordshire Designated Dr's where there is currently a vacancy 4. Telephone advice support from Berks West. 5. Additional capacity with an experience Safeguarding Nurse to provide support to Designated Nurse Safeguarding Children and Looked After Children **ASSURANCES:** 1. Bronze cell weekly meeting and establishment of a prioritisation plan and risk assessment of all activities. 2. ICP Systems Safeguarding Group. National Calls for Adults and Children Local Forums. South East Regional Safeguarding Forums. BOB Safeguarding Forum.	Services as part of recovery are planning and responding to children's and adults needs. i.e. behavioural changes and disclosures. The continuation and development Enhancing the system approach to facilitating victims to make disclosures and/or seek advice and support at the earliest opportunity. Enhancing the information sharing agreement to allow the multiagency system to share dynamic information recognising the evolving contextual landscape (apply 7 golden rules of information sharing). Regular supervision is maintained. Advertising for our Safeguarding Adult post current role holder leaves the CCG in January 2021 Manage phased return to work for Designated Doctor for Safeguarding Children and Looked After Children	n/a - CCG only risk	n/a - CCG only risk
21. Safeguarding issues and concerns	Children and adults still require appropriate safeguarding arrangements whilst at risk from infection, as too are social workers visiting homes where individuals may be symptomatic.	CCG Commissioned Services and Primary care teams are unable to identify, recognise and respond to safeguarding issues and concerns brought about through social distancing restrictions, service changes and altered staffing across all services.	inappropriate or incorrect use of MCA and MHA legislation	1. inappropriate detention, reduced assessment processes to identify vulnerable individuals and risk issues, and hidden harm risks (DA, abuse in the home, changing carer responsibilities) 2. breach of statutory duties by commissioned providers 3. increased scrutiny from regulatory agencies	**David Williams**	**Gilly Attree**	**Robert Majilton**	25 (5*5)	16 (4*4)	12 (4*3)	4 (2*2)	Numerous safeguarding referrals are coming from the police. The Coronavirus Act 2020 allows for some easements of the Care Act 2014 and the Mental Capacity Act 2005, resulting in national reports of lower levels of referrals to social services, and increased severity of injuries upon presentations. 25/06/2020 - moderated corporate risk score at 12 by CCG Executive Committee March 2021: Ongoing challenges with activity and surging caseload (Wave 2) Update 28.06.21 - Ongoing challenges with activity and surging caseload (Wave 3)	Re-deployment ended and all statutory roles filled	Immediate	**CONTROLS:** 1. Maintain and support all consultation and supervision arrangements using mutual aid if required. 2. Close working partnership with comms teams to share best practice and updated guidance in a timely manner. 3. Active involvement in all national, regional and local level safeguarding work streams to ensure parity of practice with other local areas. 4. Fortnightly multi-agency safeguarding group and weekly operational meeting between Local Authority, BHT, Oxford Health and CCG **ASSURANCES:** 1. Bi-weekly partnerships and systems meetings and bronze cells for vulnerability groups including care homes, LD, children and maternity with cross membership from safeguarding cell to align work streams.	Services as part of recovery are planning and responding to children's and adults needs. i.e. behavioural changes and disclosures. The continuation and development Enhancing the system approach to facilitating victims to make disclosures and/or seek advice and support at the earliest opportunity. Enhancing the information sharing agreement to allow the multiagency system to share dynamic information recognising the evolving contextual landscape (apply 7 golden rules of information sharing). Regular supervision is maintained. Multi-agency meeting before end of March to	n/a - CCG only risk	n/a - CCG only risk
22. CCG staff working from home and office closure/re-opening	Pandemic already underway and therefore potential for outbreak and/or deep clean of corporate office spaces given co-location at Amersham Hospital and New County Offices. Arrangements and risk assessment for office re-opening as lockdown measures ease.	CCG not appropriately and adequately prepared for lockdown measures easing	staff at increased risk of harm/infection if they return without appropriate measures	1. default to working from home arrangements 2. Re-scheduling of meetings 3. Microsoft Teams and other software for virtual meetings into effect	**Robert Majilton**	**Russell Carpenter** **Sarah Edwards**	**Robert Majilton**	25 (5*5)	12 (4*3)	12 (4*3)	6 (3*2)	Reality of formal closure initially deemed low; CCG has not since 23 March 2020 (announcement of national lockdown) formally closed either of its office. However both offices utilising skeleton staff, with all other functions delivered through working from home virtual software including switchboard calls. Lockdown measures easing in June 2020 - government guidance requires risk assessment of office spaces. There is no pressure on staff return given recognition of perceived risk, with HR position that staff continue to work from home as much as possible as is also stipulated within national guidance. When more staff return to working in the CCG's offices, staff will have to have completed an individual risk assessment and discussed their reasons for returning to work in the office with their line manager. Increased use of the offices may present an a increased risk if there are no trained fire wardens or first aiders on site on a daily basis. 23 July - risk not moderated whilst uncertainty remained over timing of re-opening. 25 August - re-opening delayed to date beyond 7 September, as yet unconfirmed. Action on staffing impact addressed through amendments to GBAF risk on staffing. September 2020 - return to offices further deferred whilst case numbers increase and social distancing (rule of six) measures in place. Had previously been aim to return on basis of 80% one day a week by end of September, but further deferred until unspecified date. Appropriate measures are otherwise deemed to be in place. **RECOMMENDATION THAT RISK IS MODERATED AT 12 TO REMAIN PRESENT ON THE CORPORATE RISK REGISTER UNTIL A RETURN TO OFFICES DATE HAS BEEN AGREED.** **October 2020: moderation at 12 agreed. RC noted James Kent had indicated at staff briefing on Monday that re-opening not expected until at least the end of January 2021.**	Offices re-opened with proportionate future split given societal culture change	Immediate	**CONTROLS:** 1. All staff asked for emergency contact details - with use of Page One text messaging system to broadcast alerts should formal office closure become a necessity. Contact lists not differentiated between Aylesbury and Amersham offices. 2. Working from home arrangements for default agreed and in place. 3. SCWCSU previously issued sufficient numbers of Virtual Private Network (VPN) tokens "always on" to all staff to mitigate against risk of lock out/insufficient VPN connectivity. 4. All staff asked to check that VPN and Mitel (telephone system) connections are working. 5. Chair's checklist - includes Microsoft Teams etiquette – top tips; Confidential matters may be discussed – Chair to remind participants as to their arrangements to ensure confidentiality – for example use of headphones where working from home in a shared house. 6. Aylesbury and Amersham office risk assessment with appropriate measures for return to the office as well as Employee Working Arrangements Return To Offices Framework. 7. Staff returning to work in either office will need to familiarise themselves with fire evacuation procedures and follow any guidance provided by landlords in relation to the designated meeting point for that building in the event of an evacuation. **ASSURANCES:** 1. Reporting through SMT on office and staffing statuses	None unless formal office closure decision deemed as required or other working from home issues identified. None other in relation to staff returning to the office - risk assessments and Employee Working Arrangements Return To Offices Framework. Already completed. Ensure staff working in either office have access to written fire evacuation procedures so they are aware of the actions they need to take in the event of a fire evacuation Owner - Sarah Edwards, timescale July 2020	n/a - CCG only risk	n/a - CCG only risk
LEARNING																		
27. Learning from the pandemic	Much has to date been learned from the pandemic, including implementing a number of initiatives (such as digital transformation) that have historically taken much longer to succeed. It is perhaps inevitable that a public enquiry or appropriate alternative will result nationally to review the pandemic and the actions taken to manage public health. Locally it is also imperative that the CCG and its ICP/ICS system partners learn from the experience in order to 1. inform future design, delivery and commissioning 2. support preparedness for future pandemic outbreaks	The CCG and its ICP do not demonstrate appropriate learning from the pandemic - in relation to clinical commissioning, design and delivery	the ICP would be unable to adjust to what becomes the "new normal"	1. non-compliance with future statutory responsibilities adjusted to reflect national learning 2. inability to meet future financial targets 3. Patient and public perception that the CCG and its partners have been unable to adapt to changing models for demand and supply of patient care	**Robert Majilton**	**Russell Carpenter**	**Robert Majilton**	25 (5*5)	12 (4*3)	12 (4*3)	12 (4*3)	Restoration and Recovery Plan to be discussed at Executive Committee 28 May 2020 and Governing Body 11 June 2020 - risk score to be reviewed once these discussions have taken place. 25/06/2020 - moderated corporate risk score at 12 by CCG Executive Committee. September 2020 - risk and score has remained unchanged	Pandemic over, learning embedded	Immediate	**CONTROLS:** 1. Restoration and Recovery planning - includes that we *Ensure that any positive lessons learnt and improvements developed during the crisis are sustained as we move forward* **ASSURANCES:** 1. Reporting on Restoration and Recovery planning through CCG Executive Committee and CCG Governing Body. 2. Reporting on restoration and recovery through CCG and ICS all staff meetings	None specific	None identified	None identified