CORPORATE RISK REGISTER: MAY 2021 COVID-19 - GOVERNING BODY ESCALATIONS

																	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
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 PtR 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 Dal 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 though standing items. 3. South Facing Bucks group who regularly review and update work streams and associated actions to rapport 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 turnour. 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 completing 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. Premature discharge back to primary care 3. Need for re-referral from primary care 4. A potential wave of activity as when referrals are opened again that may put pressure on capacity. 5. Patient conditions deteriorating leading to complexity of their conditions and greater future needs of services. 6. Which could also put a financial burden on services in the future with more demand and greater needs	**Robert Majilton**	**Dr Raj Thakkar**	**Robert Majilton**	**25 (5*5)**	**16 (4*4)**	**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 patient 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 BCx 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*
CCG FINANCES																		
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)**	25/06/2020 - 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
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 by 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) 22/09/2020: Month 3 data received - 10% growth M1, then -6% month 2, then 10% month 3. 7.5% growth project for rest of financial year. October 2020: 8.6% growth included in CCG M7-12 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. 0.68% 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	[redacted]	[redacted]
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-reimburse 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 M7-12 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)	[redacted]	[redacted]
PRIMARY CARE																		

CORPORATE RISK REGISTER: MAY 2021 COVID-19 - GOVERNING BODY ESCALATIONS

																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
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 NHSE/I 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 COVD 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 NHSE/I 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 COVD 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.
PROVIDER AND SYSTEM RESILIENCE																		
28. 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 Protecftion 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