NHS
Surrey Downs
Clinical Commissioning Group

Meeting name and date	Governing Body 27th November 2015
Agenda item & attachment number	Item 10 Attachment 6
Title of paper	Risk Profile - Month 8
Author name and job title	Justin Dix, Governing Body Secretary
Executive Lead	Matthew Knight, Chief Finance Officer
Primary Strategic Objective	Range of objectives, see below
Risk rating	Range of risks - see Executive summary
Purpose of Paper	For discussion

Summary of Key Issues

The CCG carries a greater level of risks to its principal objectives than it does to its day to day operations. Strategic risk is difficult to quantify but typically is centred on changes outside the organisation's control such as national policy, local context and technological change.
The profiles show significant risk in financial recovery & transformation. Key concerns are mitigating the risks to projects that that will deliver a sustainable health economy. See: Finance report; Finance and Performance Committee Report.
Overall quality and performance risks are good (some hotspots). See: Quality and Performance Report. Strategic risks are less easy to evaluate but the development of the spending review, Better Care Fund 2016/17, and developments in the South West London and Surrey Downs programme will be key determinants.
Organisational development, particularly localities & new governance structures will be key mitigations. The risk register shows minor variations on M7 and there are some recommended closures and areas of improvement / deterioration.

Improving care together across Surrey Downs

Compliance section

Please identify any significant issues relating to the following areas. Do not leave any boxes blank – if there are no compliance issues please state “no known issues”.

Patient and Public Engagement	Minor issues
Quality Impact	QIA undertaken - only minor issues
Equality Impact	EqIA shows only minor issues
Privacy impact	PIA to be undertaken
Financial implications	Within forecast expectations
Workforce issues	Significant workforce issues
Conflicts of interest	Conflicts of interest managed in line with policies

Additional compliance information

As the risk profiles cover all areas of the CCG's business, there are a range of compliance issues. The CCG has greatly enhanced its arrangements for impact assessments (See Chief Officer's report).

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Risk Profile Month 8 (November 2015)

Purpose

The aim of this document is to provide clear and accessible profiles and summaries of mitigating actions for:

- Risks to the CCG's principal objectives (assurance framework) – **Profile 1**
- Operational risks (risk register) – **Profile 2**
- A longer term view of risk (strategic estimates) – **Profile 3**

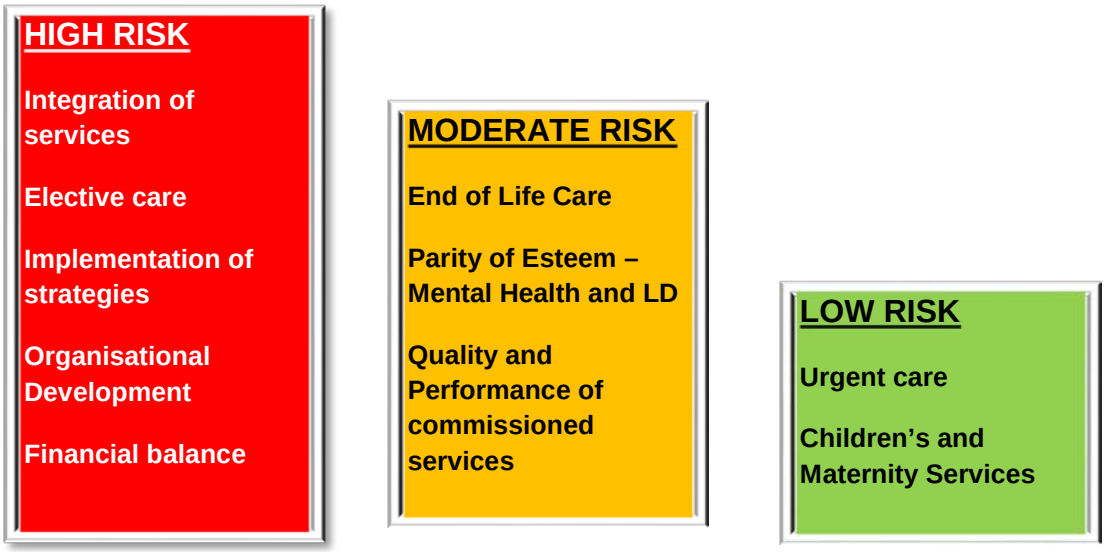
Summary

The CCG carries a greater level of risks to its principal objectives than it does to its day to day operations. Strategic risk is difficult to quantify but typically is centred on changes outside the organisation's control such as national policy, local context and technological change.

The profiles show significant risk in financial recovery & transformation. Key concerns are mitigating the risks to projects that that will deliver a sustainable health economy. See: Finance report; Finance and Performance Committee Report. Overall quality and performance risks are good (some hotspots). See: Quality and Performance Report. Strategic risks are less easy to evaluate but the development of the spending review, Better Care Fund 2016/17, and developments in the South West London and Surrey Downs programme will be key determinants. Organisational development, particularly localities & new governance structures will be key mitigations. The risk register shows minor variations on M7 and there are some recommended closures and areas of improvement / deterioration.

Profile 1: Risk to delivery of principal objectives

The assurance framework is the document that sets out the risks to the CCG's principal objectives. A copy of this is attached. In summary these are as follows:



What is the CCG doing to mitigate risks to its principal objectives?

Integration

The CCG is developing an agreed vision for integrated care with Epsom St Helier and CSH Surrey which needs investment and resourcing from alternative sources and is currently being explored, and in addition the CCG is now working with South West London CCGs as part of a programme covering South West London and Surrey Downs. There are risks to the integration agenda as capacity is focused on more QIPP related projects (although many are integration related); it is expected that this risk will be mitigated in future reports.

Elective care

The CCG has a clear vision for how to redesign care locally and this will be taken forward as part of the plan to develop a sustainable health economy. As above, greater influence over primary care will be key and there are positive indicators that local hubs and networks are having an impact but it is too soon to see what the long term impact of these will be.

Urgent care

Surrey Downs residents have enjoyed good access to urgent care with winter performance locally exceeding that of comparable systems, i.e. with A&E performance. System Resilience Groups have been effective in co-ordinating care between agencies and additional funds have been deployed effectively. The current score reflects this continued positive performance. However there may be pressures from the winter period which we are about to enter into.

End of Life Care

There has been steady improvement in end of life care as reflected in the scores but there remain issues with required software solutions and interagency working. There is a high level of integration with clinical priorities 1 and 2 in this respect and further progress will be dependent on wider system reform. The EoLC strategy was presented to the September Governing Body to take this work forward through an agreed strategy.

Improving experiences of children and maternity services

There has been significant progress on children's services throughout the year and this is reflected in the current position. The CCG now has a very robust position on joint working with the leader commissioner and Surrey County Council. There are some limits to CAMHS investment which may emerge as a risk during 2015/16 however the CAMHS Committee in Common has meeting from October onwards to agree a significant procurement the outcome of which is about to be announced.

Parity of esteem for people with mental health problems and learning disabilities

Although a joint strategy for emotional health and wellbeing has been agreed, implementation of this will only take place in successive years. This is reflected in the improvement in scores during the year but the position is now unchanged at year end until strategies are operationalised. In addition there are national requirements for investment in mental health services which may not fit with local financial recovery and other priorities.

Implementation of agreed strategies

The impact of financial recovery, the review of community hospitals and primary care commissioning indicate that existing strategies need to be reshaped to address the new local agenda. This is also supported by the themes emerging from the Governing Body review which has highlighted a need for more clarity about how different strategies are integrated and support both financial recovery and sustained quality of care.

Improving the quality and performance of commissioned services

In broad terms quality targets are being met although there are specific areas such as Healthcare Acquired Infection where there is ongoing work to resolve less tractable problems. There are a number of themes around quality in the Governing Body reviews that highlight the need for stronger assurance and improvements to the way the Quality Committee works.

Developing the organisation

The combined requirements of the Governing Body reviews, feedback from NHS England and the issuing of Directions, and the continued work on the OD and capacity plan means that the CCG will have to undertake a considerable amount of development work during the third quarter of 2015/16. However there are clear actions and once these are agreed and followed through, it is anticipated that the risk will reduce significantly in the final quarter of the year.

Achieving financial balance

The CCG now has an agreed control total for this year and a very tightly managed QIPP programme. A turnaround director has been appointed. The FRP has been shared with the Council of Members and the Governing Body and the organisational development work (above) will support delivery of the FRP. The risk will be to failure to achieve the agreed figure for this year rather than financial balance as such which will be achieved over the longer period.

Profile 2: Operational risk

HIGH RISK

- Failure to achieve QIPP
- Failure to control acute contract portfolio
- Stroke services
- Constitution
- Provider Development
- Failure to achieve quality premium

MODERATE RISK

- Safeguarding adults
- GP IT
- Impact of specialist commissioning
- Capacity and surge planning
- Business continuity
- Child safeguarding
- Catastrophic provider failure
- Potential failure of information governance
- Community equipment store
- Contract database
- Acute contract and CQUIN sign off
- Contract planning signoff
- Cancer 62 day waits
- SECAmb Cat A Perf
- Immunisation in General practice
- Homecare medicines
- Infection control
- Quality of care n care homes
- Equality duty
- Governing body and committee effectiveness
- CHC – PUPOC
- CHC Assessments
- Major incident planning
- Staffing in CSH Surrey
- Server room fire risk

LOW RISK

- Community contract sign off
- Specialist equipment in the community
- SECAmb patient transport
- Prescribing costs
- CHC retrospective claims

Operational risks have only moved slightly since the last report. As is evident from the bar charts, the majority of risks fall in the middle range.

High risks are as follows:

- Failure to achieve 2016-17 QIPP. Reviewed again at Programme Delivery Board in early November. Target date already adjusted to reflect re-forecast and out-turn to M5 and planned project level actions.
- Failure to control the acute contract portfolio - impact on Financial balance. Net score unchanged. Acute over-activity has been a significant contributor to CCG's poor financial position and a recovery plan is t in place for 2015/16. Month 6 figures continue to show some variation in overall activity as per finance report but bottom line remains as per forecast. Main concern is impact that a poor winter might have on demand led activity.
- Stroke services. Aim is to make stroke pathway an essential element of the integrated care model, so is part of wider system reform as well as being a current performance issue. Current actions are to continue to work with the provider to improve performance and to join with the Surrey CCG's Committee In Common process moving to decision in autumn 2015. This will centralise stroke services in fewer, safer clinical locations from 2016; currently an East Surrey solution is being explored.
- Constitution. There is a heightened short term risk whilst the CCG introduces new governance structures which means that these need to be incorporated into a revised constitution for submission to NHS England. It is expected that this risk will be mitigated substantially by Dec 2015 as the action plan for the issues arising from the governing body evaluation and the capacity review are clarified. Operationally the issues are being managed and roles are clear.
- Provider development. This remains high risk as the CCG's various strategic platforms for change all hinge on provider development - primary care networks, community medical teams, community services and acute services. The CCG is now part of the South West London and Surrey Downs programme - this will also explore provider development. The CCG will continue to work with emerging primary care networks and other services as above.
- Failure to achieve quality premium . Quality premium was lost in 14/15 - Discussed in quality committee and in Exec - outside possibility of some rebate. No change as at October 2015.

Other Key changes are as follows.

Improving risks

- Failure to sign off community contracts – fully mitigated this year
- Specialist commissioning – potential impact on financial balance
- Failure to deliver CHC assessments within nationally mandated timescales
- Continuing Care Retrospective Reviews (Previously Unassessed Periods of Care) team capacity
- Immunisation - training in General Practice
- Infection Control
- Transfer of chemotherapy commissioning

New risks

- Risk of fire in Cedar Court server room

Risks recommended for closure

- SECAmb Patient Transport – The Patient Transport contract was transferred to Epsom St Helier as of 1 October 2015 as part of the overall ESTH contract of which there already existed a renal PTS block. Quality management of the service forms part of the overall management of the Epsom contract and the CCG can enact levers to improve and manage quality. The risk score was revised down to 6 and it is recommended that this risk is closed.
- Staffing in CSH Surrey - Assurance received that issues identified earlier in the year have been addressed and this is no longer on the provider's risk register.

Profile 3: Strategic risk profile

Predicting the unpredictable and predicting the long term is difficult for any organisation. The Governing Body considers strategic risk in its broad sense and escalates to the assurance framework and risk register where appropriate.

Category	Examples	Short term impact	Long term impact
Local changes	• Surrey devolution requires changes to NHS configuration • Divergence in Surrey CCG approaches to hosting impacts on organisation	Probable	Certain
Surrounding programmes	• Surrounding CCG Programmes impact on Surrey Downs	Probable	Certain
National policy	• Major change to CCG configuration • New initiatives impacting on resources (historical example – Better Care Fund) • Changes in allocation formulae	Probable, difficult to predict	Certain, possibly game changing
Technology	• New high cost drugs • Continued developments in social technology e.g. The Internet of Things	Certain but gradual	Certain, possibly game changing
“Black Swan” health impact	• Antimicrobial resistance rendering establish treatments redundant • Sustained pandemic • New health need (historical example – HIV)	Possible, difficult to predict	Certain, difficult to predict

Internal Control Statement on risk management

The above profiles give the Governing Body assurance that risks are being actively considered and managed in Surrey Downs CCG at the principal, operational and strategic levels.

In addition the CCG continues to mature its approach to risk management throughout the organisation.

- Since the beginning of September over seventy senior managers have been through risk management training. The aim of this is to ensure staff are up to date with their awareness of risk and how to escalate and manage it, and to encourage a positive culture of risk management.
- The annual risk maturity evaluation will take place in December to inform the re-writing of the risk strategy in the new year.
- The internal auditors have audited the CCG's approach to risk management and have given a conclusion of "reasonable assurance", with some recommendations for improvement. These are consistent with the findings of the Governing Body reviews.

Unfortunately, due to capacity problems in the South East Commissioning Support Unit, it has still not been possible to implement the Datix risk management software. However, a meeting was held on the 18th November and action is promised to support the necessary implementation.

Organisational Objective	Risk Owner (Executive)	Main responsible committee	Title of risk	Risk Description: "There is a risk that…"	Source of risk (where does this come from)	Potential effect of the risk (what might happen)	Sources of performance information use when assessing risk	Date of last update	Updated Likelihood Score	Updated Impact Score	Updated net Score	T Value (Treat, Tolerate, Terminate or Transfer)	If "Treat", set target score at which risk can be tolerated or terminated	If "Treat" set date by which target score will be achieved	Trend	Comments	Apr-15	Jul-15	Sep-15	Nov-15	Jan-16	Mar-16
Clinical Priority 1: Maximise integration of community and primary care based services with a focus on frail older people and those with LTC	Chief Op Officer	Quality	Failure to integrate services for key vulnerable groups	The CCG might not be able to integrate primary and community services (including CHC) for key vulnerable groups as an essential part of reforming local delivery.	Currently the lack of integration reduces the quality of care for patients and does not support the CCG's overall strategic programmes e.g. Out Of Hospital strategy	Impact on quality of care and financial sustainability	PMO reports for relevant projects; re-admission data	15/09/2015	4	4	**16**	Treat	8	31/03/2015	**Deteriorating**	The CCG is developing an agreed vision for integrated care with Epsom St Helier and CSH Surrey which needs investment and resourcing from alternative sources and is currently being explored, and in addition the CCG is now working with South West London CCGs as part of a programme covering South West London and Surrey Downs. There are risks to the integration agenda as capacity is focused on more QIPP related projects (although many are integration related); it is expected that this risk will be mitigated in future reports.	**12**	**15**	**16**	**16**		
Clinical Priority 2: Provide elective and non-urgent care, specifically primary care, care closer to home and improve patient choice	Dir of Comm and Strategy	Quality	Failure to provide appropriate access to non-urgent and elective care	Insufficient pathways are reformed for this priority to be considered successful, or the providers and their associated workforce cannot be developed to sufficiently transform services.	Currently elective and non-urgent care is below optimal practice and there is a particular need to develop primary care to support improved care pathways.	Services continue to be developed in outmoded ways and both quality of care and use of resources are sub-optimal.	PMO reports for relevant projects; re-admission data	26/06/2015	4	3	**12**	Treat	8	30/03/2015	**Static**	The CCG has a clear vision for how to redesign care locally and this will be taken forward as part of the plan to develop a sustainable health economy. As above, greater influence over primary care will be key and there are positive indicators that local hubs and networks are having an impact but it is too soon to see what the long term impact of these will be.	**16**	**16**	**16**	**16**		
Clinical Priority 3: Urgent Care; Ensure access to a wider range of urgent care services	Dir of Comm and Strategy	Quality	Failure to provide access to urgent care	Paqtients will default to emergency acute settings and that A&E will be overwhelmed	Known issues about inappropriate use of urgent care access points and subsequent care pathways	Patients are treated inappropriately or admitted to inappropriate care pathways; significant resources are expended on inappropriate care causing over-activity in acute sector	PMO reports for relevant projects; A&E admission data; contrat data on use of 111; SECAmb data	26/06/2015	3	2	**6**	Treat	6	31/03/2015	**Static**	Surrey Downs residents have enjoyed good access to urgent care with winter performance locally exceeding that of comparable systems, i.e. with A&E performance. System Resilience Groups have been effective in co-ordinating care between agencies and additional funds have been deployed effectively. The current score reflects this continued positive performance. However there may be pressures from the winter period which we are about to enter into.	**6**	**6**	**6**	**6**		
Clinical Priority 4: Enhanced Support for End of Life Care Patients	Chief Op Officer	Quality	Failure to improve the end of life care experience	End of Life Care services will be inadequate and people will not be supported to die in their place of choice	Current service provision which can be improved both operationally and in terms of service design	People at the end of their lives and their families have a poor quality of life leading up to their death.	PMO reports for relevant projects; data on % patients dying at home; data from community providers via contract meetings	26/06/2015	2	4	**8**	Tolerate	8	31/03/2015	**Static**	There has been steady improvement in end of life care as reflected in the scores but there remain issues with required software solutions and interagency working. There is a high level of integration with clinical priorities 1 and 2 in this respect and further progress will be dependent on wider system reform. The EoLC strategy was presented to the September Governing Body to take this work forward through an agreed strategy.	**8**	**8**	**8**	**8**		
Clinical Priority 5: Improve experience of Children's and maternity services	Dir of Comm and Strategy	Quality	Failure to improve maternity and children's Services	Services will not be improved to best practice levels in key areas such as CAMHS, hospital and community paediatrics, and therapies for children	Current service provision which can be improved both operationally and in terms of service design	There could be a significant failure in services (particularly safeguarding) and / or a long term inefficiency in service delivery	PMO reports for relevant projects; maternity data in contracts; G&W Host CCG performance reports; reports onimplementation of young carers strategy	26/06/2015	2	3	**6**	Treat	6	31/03/2015	**Static**	There has been significant progress on children's services throughout the year and this is reflected in the current position. The CCG now has a very robust position on joint working with the leader commissioner and Surrey County Council. There are some limits to CAMHS investment which may emerge as a risk during 2015/16 however the CAMHS Committee in Common has meeting from October onwards to agree a significant procurement the outcome of which is about to be announced.	**6**	**6**	**6**	**6**		

Organisational Objective	Risk Owner (Executive)	Main responsible committee	Title of risk	Risk Description: "There is a risk that…"	Source of risk (where does this come from)	Potential effect of the risk (what might happen)	Sources of performance information use when assessing risk	Date of last update	Updated Likelihood Score	Updated Impact Score	Updated net Score	T Value (Treat, Tolerate, Terminate or Transfer)	If "Treat", set target score at which risk can be tolerated or terminated	If "Treat" set date by which target score will be achieved	Trend	Comments	Apr-15	Jul-15	Sep-15	Nov-15	Jan-16	Mar-16
Clinical Priority 6: Improving patient experience and parity of esteem for people with Mental Health and Learning Disabilities (including Dementia)	Chief Op Officer	Quality	Failure to improve mental health and learning disability services	People with mental health problems and learning disabilities will continue to be marginalised and lack proper access to service; MH may be regarded as lower priority than physical health	Current service provision which can be improved both operationally and in terms of service design; Potential delays in decision-making & action planning for pan-Surrey service improvements	Failure to improve mental health with potential knock-on effect for patients' physical health - potential increase in social isolation and manifesting problems e.g. stigma from MH conditions; suicide; impact on service user mental & physical health	PMO reports for relevant projects; monitoring reports from Surrey County Council and NE Hants and Farnham as host CCG	26/06/2015	3	4	12	Treat	9	31/03/2015	Static	Although a joint strategy for emotional health and wellbeing has been agreed, implementation of this will only take place in successive years. This is reflected in the improvement in scores during the year but the position is now unchanged at year end until strategies are operationalised. In addition there are national requirements for investment in mental health services which may not fit with local financial recovery and other priorities.	12	12	12	12		
Non-clinical priority 1: Implement agreed strategies	Dir of Comm and Strategy	Executive	Failure of strategy	Failure to implement overarching strategies e.g. Out of Hospital Strategy, Quality Improvement Strategy	CCG's own strategic programmes which are geared towards long term transformation	Although there may not be an in-year risk, the failure to make progress with individual strategies could have a significant impact on the sustainability of the CCG, its QIPP expectations, and longer term improvements for patients.	PMO reports for relevant projects; PMO dashboard	26/06/2015	4	4	16	Treat	9	31/03/2015	Static	The impact of financial recovery, the review of community hospitals and primary care commissioning indicate that existing strategies need to be reshaped to address the new local agenda. This is also supported by the themes emerging from the Governing Body review which has highlighted a need for more clarity about how different strategies are integrated and support both financial recovery and sustained quality of care.	16	16	16	16		
Non-clinical priority 2:Improve quality and performance of commissioned services	Chief Officer	Quality	Quality of commissioned services	Quality and key targets for supplier performance do not improve or deteriorate	Breadth and depth of CCG's commissioning responsibilities and diversity of contracting arrangements	This would impact on patient care and patient safety	Information from CQRGs; SIRI data on providers; infection control data; monitor ratings; CQC ratings	26/06/2015	3	4	12	Treat	8	31/03/2015	Static	In broad terms quality targets are being met although there are specific areas such as Healthcare Acquired Infection where there is ongoing work to resolve less tractable problems. There are a number of themes around quality in the Governing Body reviews that highlight the need for stronger assurance and improvements to the way the Quality Committee works.	12	12	12	12		
Non-clinical priority 3:Develop the organisation	Chief Officer	RNHR	The organisation does not change in ways that deliver the organisation's objectives	Organisational Development will not keep pace with the demands of the CCG or its own stated aims and strategies	This is an inherent risk for all organisations	Potential for gaps in workforce to undermine delivery; structures not aligned to delivery;	Staff survey; feedback from external and internal reviews	26/06/2015	5	4	20	Treat	8	31/03/2015	Deteriorating	The combined requirements of the Governing Body reviews, feedback from NHS England and the issuing of Directions, and the continued work on the OD and capacity plan means that the CCG will have to undertake a considerable amount of development work during the third quarter of 2015/16. However there are clear actions and once these are agreed and followed through, it is anticipated that the risk will reduce significantly in the final quarter of the year.	16	16	20	20		

Organisational Objective	Risk Owner (Executive)	Main responsible committee	Title of risk	Risk Description: "There is a risk that…"	Source of risk (where does this come from)	Potential effect of the risk (what might happen)	Sources of performance information use when assessing risk	Date of last update	Updated Likelihood Score	Updated Impact Score	Updated net Score	T Value (Treat, Tolerate, Terminate or Transfer)	If "Treat", set target score at which risk can be tolerated or terminated	If "Treat" set date by which target score will be achieved	Trend	Comments	Apr-15	Jul-15	Sep-15	Nov-15	Jan-16	Mar-16
Non-clinical priority 4:Achieve financial balance	Chief Fin Officer	Executive	Achieving financial balance	The CCG fails to achieve financial balance or shifts the impact into one or more subsequent financial years	Inherent risk for all NHS organisations	Direct impact on services provision; loss of flexibility; potential for NHS England to invoke conditions or directions; reputational impact	Monthly finance reports; activity data from suppliers; QIPP forecasts	26/06/2015	5	4	**20**	Treat	4	31/03/2015	**Static**	The CCG now has an agreed control total for this year and a very tightly managed QIPP programme. A turnaround director has been appointed. The FRP has been shared with the Council of Members and the Governing Body and the organisational development work (above) will support delivery of the FRP. The risk will be to failure to achieve the agreed figure for this year rather than financial balance as such which will be achieved over the longer period.	**20**	**20**	**20**	**20**		

Title of risk	ID	Status	Risk Area	Executive Risk Owner	Risk Manager	Main responsible committee	Relevant Assurance Framework Area	Risk Description: "There is a risk that..."	Source of risk (where does this come from)	Potential effect of the risk (what might happen)	Assurance (What do we know)	Gaps in assurance (What don't we know)	Controls (what can we do)	Gaps in Controls (what can we not do)	Pre-mitigation likelihood Score	Pre mitigation impact Score	Net initial Score	Date of initial score	Date of latest scoring	Likelihood Score	Impact Score	Revised Net Score	Trend (change since last Governing Body report)	Risk Appetite Treatment score	T Value (Treat, Tolerate, Terminate or Transfer)	If "Treat" set date by which target score will be achieved	Actions and Comments
Staffing in CSH Surrey	SDRR03	Awaiting closure	Quality	Chief Op Officer	OMcKinley	Quality	8 Quality and Performance	Difficulties with staffing in key areas will seriously affect CSH Surrey's Business Continuity arrangements and their ability to deliver services	Shortages of speech and language therapists and nursing staff (in community hospitals)	Patients will suffer due to loss of service,in particular experiencing longer waits or transfers to other locations	Loss of service is real and has already occurred more than once.	Future market trends in both supply and end employment markets not easy to predict	Controls are with supplier - active recruitment processes, use of alternative sites and services	Low control over higher incentives to work e.g. in London	4	4	16	01/02/2015	23/10/2015	2	4	8	Improving	Low 6-8	Treat	30/09/2015	Assurance received that issues identified earlier in the year have been addressed and this is no longer on the provider's risk register. Recommended for closure.
Stroke services	SDRR04	Open	Quality	Dir of Comm and Strat	TElrick	Quality	8 Quality and Performance	Risk that poor performance at Epsom will continue and that there will be delays in resolving Surrey wide issues with designating specialist sites.	Poor configuration of services in Surrey; need for services to have adequate volumes of patients to maintain clinical skills; workforce supply problems	Direct impact on patients e.g. poor clinical outcomes etc	Current volumes at clinical sites across the county are known and there is a process in place for reconfiguring services	No significant gaps in assurance	Work within current process and continue to press Epsom for improved local performace	Limited controls over workforce supply shortages; Epsom performance is largely in supplier's hands	4	4	16	31/03/2015	10/11/2015	4	4	16	Static	Zero 1-5	Treat	31/03/2016	Aim is to make stroke pathway an essential element of the integrated care model, so is part of wider system reform as well as being a current performance issue. Current actions are to continue to work with the provider to improve performance and to join with the Surrey CCG's Committee In Common process moving to decision in autumn 2015. This will centralise stroke services in fewer, safer clinical locations from 2016; currently an East Surrey solution is being explored.
Provider development	SDRR07	Open	Commissioning	Dir of Comm and Strat	Jblythe	Executive	7 Strategy	Providers, particularly community services and primary care networks, may not develop sufficiently to deliver the CCG's strategy	The need to integrate provider activities to develop more cost effective and high quality services in line with the five year forward view	Failure to integrate care and achieve the necessary transformation	Information exists on current provider development through contractual mechanisms and transformation boards	There are significant gaps in knowledge nationally as to what the most effective provider and market mechanisms are	Contracts; negotiated agreements and potential joint ventures	Ultimately individual organisations ands their boards can reserve the right to take unilateral decisions	4	4	16	09/02/2015	15/09/2015	4	4	16	Static	Low 6-8	Treat		This remains high risk as the CCG's various strategic platforms for change all hinge on provider development - primary care networks, community medical teams, community services and acute services. The CCG is now part of the South West London and Surrey Downs programme - this will also explore provider development. The CCG will continue to work with emerging primary care networks and other services as above.
Risk to child safeguarding	SDRR08	Open	Quality	Chief Op Officer	EClark	Quality	5 Children and Maternity	Child safeguarding arrangements will not be adequate	Child Safeguarding structures are hosted by another CCG and there are complex multi-agency arrangements in place which have the potential to break down.	Potential risk of harm to vulnerable children; significant reputational risk	The host commissioner provides regular reports to the CCG which sets out the main issues and risks relating to child safeguarding. SD CCG also has representation on the Health Sub-group and Area Safeguarding Groups which provide assurance; reporting through CQRMS	None identified	The CCG has a Service Level Agreement with Guildford and Waverley CCG (as hosts of this service) to lead on Safeguarding Children. There are also established multi-agency structures and processes in place across Surrey which can be used to initiate action where a concern exists.	None identified	4	3	12	01/04/2013	23/10/2015	2	4	8	Static	Min 1-5	Treat		SCC reported to SDCCG Quality Committee October Seminar. This provided assurance on the SCC action plan. New Chair in place for children's safeguarding board.
Transfer of chemotherapy commissioning	SDRR09	Draft	Medicines Management	Dir of Comm and Strat	Sarah Walkin	Executive	2 elective and non urgent care	Proposed transfer of chemotherapy commissioning to CCGs will not be clinically and / or financially safe	Transfer of chemotherapy commissioning within 5 year cancer strategy (July 2015) - indicates lead CCG commissioning model for 4-5m population. Plans to be completed by end 2015/16 for implementation 2016/17.	The potential impacts are clinical (risks of poor clinical decisions for patients); financial (loss of financial control); inequity of access; operational (if MM have to host);p links to IFR); and reputational (CCG may be subject of media attention if patients suffer as a result of the changes)	The CCG is aware of discussions in the area team but no formal notification nor indications of operational arangements	The medicines management has identified ten key areas on which there is a lack assurance on the proposed transfer; these are around specialism, timescales, boundaries, future of the cancer drugs fund, workforce, collaboration and scale of financial risk.	Has been raised with national pharmacy advisory group and NHS England meds opt CRG and SE Coast commissioning chief pharmacists to ensure visibility of issue see VO's detailed paper	The CCG lacks budgetary control (including scale of financial risk), and workforce control. Also may not have control over appointmen of lead CCG	3	5	15	01/09/2014	11/11/2015	3	4	12	Improving	Min 1-5	Treat	31/12/2015	No actions other than those described under controls - CCG awaits further guidance from NHSE and proposal for host CCG arrangements, however unlikely to be an issue in this financial year so risk lowered pending furether information.
Specialist Equipment in the community	SDRR10	Open	Quality	Chief Op Officer	EClark	Quality	8 Quality and Performance	The CCG is not assured that certain historically provided specialist equipment being used by healthcare staff in the community is fit for purpose.	There is a central database detailing specialist equipment held by Millbrook (SP), but some old equipment may not be on this system.	Potential risk of harm to patients and operators of the equipment	Some databases of equipment in use. Feedback from health and social care staff working directly with patients about equipment they are aware of.	Inadequate assurance on providers processes / insufficient information about historical equipment still in use.	Contractual levers for monitoring equipment in use in the community.	No direct controls over old equipment that is not on anyone's inventories.	3	3	9	01/04/2013	23/10/2015	2	3	6	Static	Low 6-8	Tolerate		Risk is 'tolerated' because we are not able to directly influence the situation but are assured that the current process for equipment going forward is robust. Providers offer first line of defence against potential incidents occurring. Propose this is closed at next Governing Body as risk sits with providers.
Catastrophic Provider failure	SDRR11	Open	Quality	Dir of Comm and Strat	EClark	Quality	8 Quality and Performance	An unexpected clinical failure of a Provider takes place that reveals and is attributable to either a lack of early warning systems or cultural issues within the organisation that conceal significant quality and / or patient safety issues.	Following the issues at Mid Staffordshire, all health economies run the risk that there is a potential unexpected failure of an organisation-wide nature.	Harm to patients, global reputational issues for the health economy	The CCG monitors a basket of indicators including mortality rates through contract meetings and other mechanisms; monitoring of serious incidents and other early warning signs; Surrey wide patient safety networks in place.	None identified	Direct interaction with suppliers to change organisational culture. Intervention through contracts. Performance notices and penalties in some areas.	None identified	4	4	16	01/04/2013	23/10/2015	2	4	8	Static	Low 6-8	Tolerate		No change to net score. Main concerns are with care homes rather than big suppliers. Processes for early warnings are now improved and support a rapid response where needed. Risk appetite score redefined as this will always be a risk in any health economy and the current systems and processes are adequate within resource constraints.
Infection Control	SDRR12	Open	Quality	Dir of Comm and Strat	EClark	Quality	8 Quality and Performance	Significant failings with occur in commissioned services in relation to Health Care Acquired Infection	Local Providers may fail to meet agreed quality standards around Health Care Acquired Infection practice with the subsequent risk to patient safety and experience. Also lack of in depth expertise and capacity in this area across Surrey CCGs to enable robust monitoring. DH requirements for investigation of incidents.	Actual or potential harm to patients. In addition, the CCG will fail to achieve the standards required to receive part of the quality premium payment attached to these standards.	CQRMs with Acute and Community Providers and AQPs; Overview, advice and data from the infection control prevention lead in Public Health; Qtly meeting of Providers and Commissioners (SIPC) and AT HCAI meetings. CCG antibiotic prescribing audit & follow up with GP practices; NHSE AT contract monitoring with independent contractors. CQC monitoring.	None identified	Contract meetings and contract levers; performance management and withholding of payment.	No operational level expertise and capacity within the CCG quality team or Surrey Public Health team to undertake in depth investigations and monitoring required.	4	4	16	01/04/2013	23/10/2015	3	3	9	Improving	Min 1-5	Treat	31/03/2016	Recent experience with care home infections shows that systems are effective. CCG continues to work collaboratively acros Surrey to identify effective ways to share capacity and resource.Needs to be closely monitored over winter period.
Safeguarding Adults	SDRR13	Open	Quality	Chief Op Officer	EClark	Quality	8 Quality and Performance	Potential for preventable harm to Surrey Downs (and Surrey) residents and patients due to lack of resource and capacity in relation to adult safeguarding - specifically commissioners' ability to scrutinise suppliers systems and receive adequate assurance.	Surrey is a complex county with six commissioning CCGs and only one person in the host organisation to co-ordinate activities.	Actual harm to individuals; reputational risk to the NHS.	Weaknesses - Critical audit report Oct 2015 has highlighted risks arising from lack of resource and gaps in process co-ordination. Normal assurance - The Surrey Safeguarding Adults Board and Sub-Committees provide oversight of all agency activities; the CCG quality committee receives regular reports from the Designated Nurse identifying risks; analysis of relevant Serious incident with safeguarding implications.	None known	Surrey CCG Quality Leads discuss Adult Safeguarding monthly where the issues are monitored. Bi-monthly meeting of NHS Adult Safeguarding Leads across Providers in Surrey. Multi Agency Safeguarding Hub (MASH) in Surrey. New health sub group for safeguarding adults commences 30th April 2015.	MASH is in place but not yet fully functioning. External review and awayday planned to address issues.	4	3	12	01/04/2013	23/10/2015	3	4	12	Deteriorating	Min 1-5	Treat		Net Score revised from 4 to 12 as a result of issues identified in internal audit report. As a result of this an action plan has been put in place to bring the risk back within tolerance levels. Update to quality committee on 3rd November and subsequently to Governing Body end November.

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Care home failures	SDRR14	Open	Quality	Chief Op Officer	EClark	Quality	8 Quality and Performance	Potential for residential and nursing homes in the local area to experience difficulties and / or fail.	The care home market is a volatile one and there are issues with recruitment of staff and maintenance of standards. Monitoring and compliance regimes are still underdeveloped.	Actual harm to individuals. Reputational risks to the NHS and joint agencies.	Surrey CCG Quality Leads discuss Safeguarding issues six-weekly where the work plan is monitored. Regular intelligence sharing forum being developed between CCG Quality Leads, SCC QA team and CQC to focus on providers. Bi-monthly meeting of NHS Adult Safeguarding Leads across Providers.	Intelligence is not always well co-ordinated.	Ability to de-register and close homes; CQC compliance actions; adult safeguarding interventions.	No gaps identified	4	3	12	01/04/2013	23/10/2015	4	2	8	Static	Low 6-8	Tolerate		This is an ongoing risk which may escalate dependent on the development of the wider market for care homes. Reviewed in care homes forum. No change.
Quality of care in Care Homes	SDRR15	Open	Quality	Chief Op Officer	EClark	Quality	8 Quality and Performance	The nursing care provided in care homes and care homes with nursing in Surrey Downs (and Surrey) is not of a suitable standard to ensure the safety and well-being of residents	Variable standards of care from a range of small and large providers highlighted by - Safeguarding referrals - Serious incident reporting - Complaints - Soft intelligence - CQC reports	Actual harm to individuals. Reputational risks to the NHS and joint agencies.	Shared intelligence through: Area Quality Surveillance Group Surrey-wide Quality Leads CCG and SCC monthly meeting CQC reports; compliance action and ability to de-register and close homes. CHC Team service reviews and individual case reviews	Intelligence is not always well co-ordinated.	Adult safeguarding interventions; Contractual sanctions: remove or suspend placements.	No gaps identified	4	3	12	16/01/2015	23/10/2015	4	3	12	Static	Low 6-8	Treat	31/03/2015	Development of a Surrey-wide dashboard still ongoing. Capacity will probably prevent achieving desired tolerance levels unless additional resource provided.
Failure to achieve quality premium	SDRR18	Open	Finance	Dir of Comm and Strat	EClark	Quality	8 Quality and Performance	Quality premium payments are directly linked to achievement of supplier standards and targets and CCGs are effectively penalised for not achieving these	Quality premium payments are directly linked to achievement of supplier standards and targets and CCGs are effectively penalised for not achieving these	Impact on patients; loss of income to the CCG; reputational damage	Supplier actions relating to Quality Premiums are actively monitored by the quality team and Clinical Quality Committee; enhanced performance reporting is being introduced	None known	Contractual levers	None known	4	4	16	01/04/2013	27/10/2015	4	4	16	Static	Low 6-8	Treat		Quality premium was lost in 14/15 - Discussed in quality committee and in Exec - outside possibility of some rebate. No change as at October 2015.
Major incident preparedness	SDRR19	Open	EPRR	Chief Op Officer	Jperrott	Executive	Other / operational	Risk that Surrey Downs CCG will be unable to discharge its responsibilities as a Category 2 responder in the event of a Major Incident or surge in demand, and will not have generally robust on-call arrangements	As a statutory body the CCG has responsibilities for a range of commissioned services and a duty to collaborate with NHS and other organisations to ensure that health services are maintained under abnormal circumstances (e.g. severe winter weather) and in the event of an actual major incident.	Impact on patient / public safety and use of resources. Reputational impact of failing to respond appropriately.	Using the EPRR assurance process the CCG has a good picture of its EPRR arrangements and where improvements are needed.	No significant gaps	Maintain policies and procedures; provide regular training for staff;	Local plans and policies have only been partially tested.	4	4	16	01/04/2013	09/11/2015	2	4	8	Static	Min 1-5	Treat	02/01/2015	EPRR assurance Going to Nov Governing Body for sign off - including MI preparedness.
Potential failure of Information Governance	SDRR20	Open	Information Governance	Chief Officer	JDix	Executive	Other / operational	Surrey Downs CCG will be adversely affected by failure to meet high standards of information governance (NHS IG Toolkit)	Uncertainty over arrangements for data security, management of records and other elements of the I G Toolkit for managing information safely, securely and effectively	Potential loss of patient identifiable information; poor management of data leading to impact on business; reputational impact; in severe cases, fines and legal action by the information commissioner	IG Action Plan gives a clear picture of compliance on a monthly basis throughout the year	None known	Work through Information Asset Owners and Data Custodians to improve IG toolkit scores; ensure staff undertake training. IG steering group.	Influence over CSU technical controls is limited.	4	4	16	01/04/2013	09/11/2015	2	4	8	Static	Zero 1-5	Tolerate		Interim additional capacity has been bought in to ensure that there is robust preparation for completing the 2015/16 IG Toolkit submission. Risk maintained at current levels whilst these issues worked through. Initial IG Audit commences 20th November
Equality Duty	SDRR21	Open	Corporate	Chief Op Officer	JDix	Executive	9 Organisational Development	Risk that Surrey Downs CCG will fail to comply with the 2010 Equality Act and face regulatory action	Statutory nature of the CCG's equality duty which is reiterated in the NHS constitution	The CCG may fail to discharge its commissioning and / or employer functions in line with the law. This would mean that it was not meeting the needs of protected groups e.g. people with disabilities, age specific groups, faith, gender etc. both as a commissioner and employer	Policies and objectives in place and monitored by the Quality Committee; public health profiles give substantive assurance on equality issues in local population	Lack of detailed knowledge about own workforce	Implementation of Equality Objectives; use of EDS2 to measure and improve CCG's equality action plan	None identified	4	5	20	01/09/2013	09/11/2015	3	4	12	Static	Low 6-8	Treat	31/03/2015	New engagement manager in post however CCG cannot demonstrate that it has made progress e.g. with EDS2. Recommend continue tolerating risk at this level until next review. CCG is undertaking some joint work with other CCGs and has revised its equality impact policy however further progress is needed.
Business continuity	SDRR22	Open	EPRR	Chief Op Officer	Jperrott	Executive	Other / operational	Inadequate business continuity plans will mean that the CCG is incapable of functioning or that there will be an extended recovery time before normal service is resumed.	Adverse incidents such as weather, fire, terrorist incident, pandemic illness impacting on day to day running of the organisation	Loss of buildings and IT; unable to access records and communicate with other organisations; loss of services to patients e.g. CHC. IFR and RSS; if prolonged, inability to pay contractors in a timely way and to maintain commissioning functions	Business continuity policy and plans in place; some staff training conducted; outcomes of audit of business continuity arrangements (Oct 2014) have informed actions	Lack of testing of policies and plans; no measures of wider staff awareness of business continuity issues	Heads of service tasked with ensuring business continuity mechanisms are in place on a team by team basis	Lack of control over landlord actions in relation to premises; low control over e.g. pandemic flu and weather that could impact on staffing	3	5	15	01/04/2013	09/11/2015	2	4	8	Static	Low 6-8	Tolerate	30/11/2015	Business continuity plans being updated.
Constitution	SDRR25	Open	Corporate		JDix	Executive	9 Organisational Development	Risk of the constitution not being fit for purpose	Inherent risk in all CCG's governance	Risk that decisions of the Group, Governing Body or its constituent parts might be invalidated; risk of judicial review; reputational risk	Constitution and its dates of amendment are in the public domain	No gaps identified	Constitution has been updated on three occasions by Group and fourth amendment pending; constitution is regularly reviewed by Governing Body Secretary	NHS England sign off required	3	4	12	01/04/2013	09/11/2015	4	4	16	Static	Medium 9-12	Treat	31/12/2015	There is a heightened short term risk whilst the CCG introduces new governance structures which means that these need to be incorporated into a revised constitution for submission to NHS England. It is expected that this risk will be mitigated substantially by Dec 2015 as the action plan for the issues arising from the governing body evaluation and
Governing Body and Committee effectiveness	SDRR26	Open	Corporate	Chief Fin Officer	JDix	Audit	Other / operational	The Governing Body and Principal Governing Body Committees are ineffective or fail to co-ordinate their assurance roles	Inherent risk in all CCG's governance	Loss of strategic and operational control; inability to comply with the requirements of the annual governance statement; potential impact on ongoing authorisation	Feedback from auditors in internal controls; feedback from committee chairs	No formal review process for individual committees following 2013/14	Review of governing body committee effectiveness underway using external facilitation and structured surveys of GB and committee members	None identified	4	3	12	01/04/2013	09/11/2015	4	3	12	Static	Low 6-8	Treat	31/07/2015	Reviews conducted by GT, OECam and PWC - numerous recommendations for governance including composition and behaviours of Governing Body and Committees. Being worked through with Gov Body and Council of Members during November and December and with external legal advice
CHC Retrospective claims impact on Financial balance in 215/16	SDRR27	Open	Finance	Chief Fin Officer	Dbrown	Executive	10 Financial Balance	Risk that SDCCG inherits an unforeseen deficit as a result of the ongoing issues and risks around historic (i.e. pre April 2013) CHC retrospective claims	History of retrospective claims arising from transition period	The CCG could have to deal with a significant non-recurrent cost pressure	Minimal assurance available based on PCT final accounting processes	Lack of specific and credible financial reporting in the final period of 2012-13, and conflicting policy statements during 2013/14	The CCG has minimal control over this issue other than to escalate the understanding of the impact to NHS England.	Control mechanisms within NHS England are not clear	4	4	16	02/04/2013	10/11/2015	1	3	3	Static	Low 6-8	Tolerate	01/04/2016	There are now risk pooling arrangements in place (and there was an underspend in 2014/15). Remains low risk.

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Homecare medicines safety	SDRR29	Open	Medicines Management	Dir of Comm and Strat	Sarah Watkin	Executive	8 Quality and Performance	Risk that community patients may not receive a safe service in specific clinical areas.	Medicines are increasingly managed at home rather than via acute trusts as this provides the best and most cost effective service. However there have been instances of supplier failure that potentially leave patients in an unsafe position.	Clinical risk (potential for harm) to patients	Feedback from all providers on necessary assurance that actions required through patient safety alerts will be carried out	None	Continue to seek assurance from providers through regular reports that there have been no incidents.	None identified	3	4	12	02/06/2014	11/11/2015	4	3	12	Static	Medium 9-12	Tolerate		No gaps in assurance from providers since last report - providers have provided required assurance and are working with homecare companies but this does remain a risk that needs to be kept under review.Situation believed to be lower risk but no formal assurance as yet.
Immunisation - training in General Practice	SDRR31	Open	Quality	Chief Op Officer	Mwinnan	Quality	8 Quality and Performance	There is a gap between actual staff training and current requirements due to changes in the immunisation framework.	Lack of standardised immunisation training that is rolled out consistently across the patch	Actual patient harm, particularly to vulnerable groups but also the general population	Public Health England informatioon and qualitative feedback from practice staff.	Qualitative information is not comprehensive - not all practice positions are known.	Setting up and rolling out training; education of practice nurses by PHE on their roles and responsibilities, facilitated by SDCCG	Surrey Downs CCG cannot enforce training - responsibility lies with individual practtioners / practices.	4	3	12	05/05/2015	23/10/2015	2	4	8	Improving	Low 6-8	Tolerate	31/12/2015	Under active discussion in quality team, training programmes developed, further work needed on getting ownership of this in general practice. Redefined as within tolerance on basis of training that has taken place and planned but needs to be monitored in future.
SECAmb Cat A Performance	SDRR32	Open	Performance	Dir of Comm and Strat	Telrick	Quality	3 Urgent Care	Risk that SECAMB cannot ensure acceptable performance in relation to Category A response times.	SECAMB published performance information	Risk of potential harm to patients; impact on NHS reputation	Published statistics; feedback from patients' representatives; shared intelligence from new joint commissioner's meetings	Commissioners do not have visibility of Trust action plans	Contractual levers	CCG is associate commissioner and cannot take unilateral action	4	3	12	01/11/2013	10/11/2015	4	3	12	Static	Low 6-8	Tolerate	31/03/2016	Red 1 (defib required) is being met Red 2 all (other) is not being met. A review of harm to patients where standards not met is done and an analysis of this is being discussed at quality committee. No further actions possible whilst outcomes of host commissioner actions is awaited.
SECAmb Patients transport	SDRR33	Awaiting closure	Performance	Dir of Comm and Strat	Telrick	Quality	8 Quality and Performance	Risk that SECAMB cannot achieve acceptable performance in relation to Patient Transport response times.	SECAMB Patient Transport performance is currently below expectations.	This impacts on patients and carers and can also impact on acute trusts and others where patients miss appointments or cannot be discharged in a timely fashion. Potential financial impact from mismatch between expected and actual demand (cost pressure on budget)	Published statistics; feedback from patients' representatives; shared intelligence from new joint commissioner's meetings; minutes from SECAMB and Acute Trust monthly meetings	None known	Contractual levers; tender for new service in 15 months led by host commissioner (NW Surrey CCG)	CCG is associate commissioner and cannot take unilateral action	4	3	12	02/11/2013	27/10/2015	2	3	6	Static	Low 6-8	Terminate		The Patient Transport contract was transferred to Epsom St Helier as of 1 October 2015 as part of the overall ESTH contract of which there already existed a renal PTS block. Quality management of the service forms part of the overall management of the Epsom contract and the CCG can enact levers to improve and manage quality. The risk score was revised down to 6 and it is recommended
Capacity and surge planning	SDRR34	Open	EPRR	Dir of Comm and Strat	TElrick	Executive	Other / operational	There is a risk of potential failures of service quality, financial stability, or business continuity that impact on patients and may cause harm in periods when there is a surge in demand (such as winter, heatwaves or during a pandemic) are not adequately planned for.	Severe weather, high levels of demand, seasonal 'flu or other conditions, can impact on the demand for services and also interrupt the supply and delivery of commissioned care.	Services are unavailable or subject to long waits; cancellation of elective treatment; significant impact on A&E departments, community hospitals, primary care and patient transport. Can also impact adversely on the CCG's financial and performance outturn at the end of the year if	All health economies are producing new Organisational Resilience and Capacity (ORC) plans. The NHS England Area team provides a system wide assurance function.	None known	New System Resilience Groups (SRGs); arrangements flexed arrangements for community beds to support discharge and manage system pressures. Additional investment to support capacity planning. Following each surge period e.g. Easter there are now	The CCG is one of several organisations at local level and does not have complete control over system wide interventions, particularly the role of the ambulance service.	4	4	16	01/04/2013	10/11/2015	2	4	8	Static	Low 6-8	Tolerate	31/12/2015	Currently risk reduced as system working relatively well as a result of seasonal trends, other than some issues in the Kingston area. System resillience forums in place and specialist funding allocated.
GP IT infrastructure	SDRR35	Open	Commissioning	Chief Op Officer	Jwilmshurst-Smith	Executive	Other / operational	Ageing computers, peripherals and network connections could fail or have insufficient capacity to manage practice workload.	Limited resources available and the uncertain year-on-year nature of the allocation process for the South of England.	Ageing or non-functioning IT equipment could lead to failings with patient record keeping, and the ability to communicate between services. This could have both operational and clinical consequences. Strategically, out of date GP IT will not support CCG strategies for Out of Hospital care and programmes sponsored by Transformation Boards that seek to modernise health care. GP IT could lag behind that of other stakeholders.	Baseline of equipment needs established in year 1.	Lack of clarity about future NHS England processes and timescales.	Rollout of IT refresh programme	None known	4	4	16	01/04/2013	09/11/2015	4	3	12	Deteriorating	Medium 9-12	Tolerate		CCG submitted capital bids to NHS England in January 2015 to maintain existing systems at an appropriate level of obscolesence - formal outcome is bids approved - risk increased as there is little visibility of work being undertaken by CSU to meet deadlines.
Continuing Care Retrospective Reviews (Previously Unassessed Periods of Care) team capacity	SDRR37	Open	Continuing Health Care	Chief Op Officer	LHart	Executive	1 Integration of care	Risk that Continuing Healthcare team will not be able to meet the demands for retrospective assessments ands payments	Management of applications for retrospective payments	Patients and family may wait for a long time for the result of their application and payment	CHC Review has now been implemented and efforts are being made to find better ways of meeting the retrospective workload	None known	Transformation of Service arising from review	Ability to recruit appropriately skilled staff due to model of service	4	4	16	01/04/2013	10/11/2015	3	2	6	Improving	Low 6-8	Tolerate	31/12/2015	PUPOC business case now approved and contract awarded - assessments on track, review again in new year.
Failure to deliver CHC assessments within nationally mandated timescales	SDRR38	Open	Continuing Health Care	Chief Op Officer	LHart	Executive	1 Integration of care	Risk that the nature and scale of normal continuing care applications cannot be managed	Unpredictable nature of levels of applications; capacity of team to meet demand, and methods of working	Impact on patients and carers. potential serious financial pressures and further backlogs and delays, including impact on acute hospital activity	CHC Review has now been implemented and efforts are being made to find better ways of meeting the ongoing CHC workload	New database not yet procured which inhibits ability to manage and report performance.	Recruitment of additional / replacement staff; prioritisation of claims for people who are still alive and requiring support.	None known	4	4	16	01/04/2013	10/11/2015	3	2	6	Improving	Low 6-8	Tolerate	30/09/2015	Bi-weekly performance meetings ensure all localities are within target thesholds, will continue to be closely monitored.
Acute Contract and CQUIN sign off	SDRR41	Open	Contracting	Chief Fin Officer	Mcostello	Executive	Other / operational	There is a failure to sign off 2015/16 contracts and their associated CQUINs	Contracting is a prime function of the CCG that impacts across domains of quality, finance and performance	Loss of control over finance and performance of any supplier without a contract	CCG has a contract database and is clear on which contracts and CQUINS are in place.	CCG does not yet have contracts in place for all suppliers, specifically St George's and Kingston.	CCG is in continued negotiation on unsigned contracts and CQUINS.	None known	5	3	15	08/04/2015	11/11/2015	4	3	12	Static	Min 1-5	Treat	31/05/2015	P(rocess ongoing. At end of August 75% of contracts had been signed, excluding AQPs which are subject to a separate process.
2016/17 Contract planning cycle	SDRR42	Open	Contracting	Chief Fin Officer	Mcostello	Executive	Other / operational	The 2016/17 Annual Contract planning and monitoring cycle is poorly managed	Policy and capacity constraints may make it difficult to adequately manage the contract planning cycle.	Poor commissioning for 2016/17; potential loss of financial control and control over other areas e.g. contract quality.	Focus on business intelligence and adequate supporting data, and improving the contract challenges to mitigate financial risk.	None known	Contract documentation, contract penalties, Exec to Exec negotiation and intervention	None known	4	4	16	08/04/2015	11/11/2015	3	4	12	Static	Low 6-8	Treat	31/09/2015	CCG will aim to be ahead of timetable compared to previous years to successfully mnitigate this risk fully. Organisation wide review of capacity / OD plan aims to ensure there is adequate capacity in place.
Contract database	SDRR43	Open	Contracting	Chief Fin Officer	DBrown	Executive	Other / operational	The contact database fails to adequately capture all contracts and aligned payments	Adequate contract database arrangements are a prime component of overall business and financial control	Loss of financial control	Contract database being developed in finance team	None known	Executive Committee; Audit Committee	None known	4	4	16	04/04/2014	10/11/2015	3	3	9	Static	Low 6-8	Treat	05/09/2015	Database now functioning but community and smaller contracts needs to be monitored before further review of this risk and risk score.

Title of risk	ID	Status	Risk Area	Executive Risk Owner	Risk Manager	Main responsible committee	Relevant Assurance Framework Area	Risk Description: "There is a risk that..."	Source of risk (where does this come from)	Potential effect of the risk (what might happen)	Assurance (What do we know)	Gaps in assurance (What don't we know)	Controls (what can we do)	Gaps in Controls (what can we not do)	Pre-mitigation likelihood Score	Pre mitigation impact Score	Net initial Score	Date of initial score	Date of latest scoring	Likelihood Score	Impact Score	Revised Net Score	Trend (change since last Governing Body report)	Risk Appetite Treatment score	T Value (Treat, Tolerate, Terminate or Transfer)	If "Treat" set date by which target score will be achieved	Actions and Comments
Failure to achieve 2016-17 QIPP	SDRR44	Open	Finance	Chief Fin Officer	Goookman	Executive	10 Financial Balance	Risk that the CCG cannot deliver QIPP schemes as agreed	Inability to deliver the change required across a number and range of projects No contingency built into QIPP FRP	Significant impact on the CCG's ability to achieve financial balance within an acceptable quality range; knock on effect to future strategies.	There is good reporting through the PMO structures across 27 projects regarding the current and forecast levels of QIPP delivery. QIPP achievement as a proportion of budget is also reported monthly.	Uncertainties with some data lags and delays in reporting; third party assurance requirements may not be consistent with CCG requirements.	QIPP re-profile and re-forecast has been undertaken and the CCC is now forecasting £9.8m delivery at year end against the original £12.8m target. This has been accepted by the Executive Team and NHSE. Detailed milestones linked to benefits for planned care projects will be requested by PMO. Ability to direct organisational culture; restructuring of capacity; close management of project risks and issues; ability to vire between	Control over patient demand and supplier / third party behaviour is limited; some QIPP schemes are untested and forecast value may vary; difficulties with forecasting future supplier compliance; buy in to QIPP projects by referrers uncertain.	4	5	20	13/07/2014	09/11/2015	4	4	16	Static	Low 6-8	Treat	31/12/2015	Reviewed again at PDB early November. Target date already adjusted to reflect re-forecast and out-turn to M5 and planned project level actions.
Failure to control the acute contract portfolio - impact on Financial balance	SDRR46	Open	Finance	Dir of Comm and Strat	Mcostello	Executive	10 Financial Balance	Risk that acute hospital spend cannot be controlled leading to a significant year end deficit	The CCG contracts with three local and a large number of more distant (i.e. London) providers with a history of over-performance that generates significant financial pressure.	Significant potential impact on the CCG's ability to achieve financial balance and knock on effect to future investment strategies.	The CCG receives relatively good information on local providers through SLAM and SUS reporting and is actively managing or contributing to the management of these contracts.	Uncertainties with some data lags and delays in financial reporting;	The CCG controls contracts through regular meetings and use of contract challenges and provisions	Difficulties with non-local contracts and specialist commissioning - lack of control	5	4	20	05/08/2014	11/11/2015	4	4	16	Static	Low 6-8	Treat	31/03/2016	Net score unchanged. Acute over-activity has been a significant contributor to CCG's poorfinancial position and a recovery plan is t in place for 2015/16. Month 6 figures continue to show some variation in overall activity as per finance report but bottom line remains as per froecast. Main concern is impact that a poor winter might have on demand led activity.
Failure to control prescribing costs - impact on Financial balance	SDRR47	Open	Finance	Chief Fin Officer	S'arah Walkin	Executive	10 Financial Balance	Risk that prescribing spend cannot be controlled leading to a significant year end deficit	Historically this has been a difficult area of spend to control, and is dependent on the behaviour of a large number of clinicians who have the power to prescribe.	Significant potential impact on the CCG's ability to achieve financial balance and knock on effect to future investment strategies.	Data on prescribing spend is available through the national systems	Uncertainties with some data lags and delays in financial reporting;	Medicines Management team are proactive in supporting practices to reduce and control spend through a wide range of initiatives. CCG has budgeted adequately for this year.	No absolute control over individual prescribing behaviours.	3	3	9	05/08/2014	11/11/2015	2	3	6	Static	Low 6-8	Tolerate	28/02/2015	Prescribing costs running within budget - no indications of excessive run rate this stage. No change to risk score.
Cancer wait 62 days	SDRR48	Open	Performance	Dir of Comm and Strat	MWu	Executive	8 Quality and Performance	Risk of not meeting 62 day cancer performance target	There is an issue involving some cancers specialities between Epsom and the tertiary provider.	Potential harm to patients; reputational risk.	Good levels of performance data are available on a routine basis	The reasons for the difficulties in specific pathways are not known and are being investigated (see comments)	Limited performance leverage	No control over clinical behaviours in trust	4	3	12	27/11/2014	23/10/2015	4	3	12	Static	Zero 1-5	Treat	30/06/2015	Risk refreshed for 2015-16. Any patient who breaches 100 days should be subject to an RCA and any 62 day breach subject to an investigation. The trust's action plan is being updated and kept under review by the Quality Committee.
Impact of transfer of specialist commissioning liability on Financial balance	SDRR49	Open	Finance	Chief Fin Officer	Dbrown	Executive	10 Financial Balance	Risk that specialist commissioning liabilities will impact significantly and negatively on the CCG's ability to achieve its control total	National programme of apportioning increased specialist commissioning costs to CCG commissioners	Impact could be significant for individual CCGs - no accurate estimates as yet.	Some indications of scale of transfer that we will need to make provision for	Precise level of liability unknown	Virtually no control over this process - nationally determined	See controls	4	4	16	05/08/2014	15/09/2015	2	4	8	Improving	Low 6-8	Tolerate		£4.7m has been incorporated into budgets for this year – . Future risks around specific areas e.g. morbid obesity and renal. Some minor income from SC but no new guidance on potential top slicing.
Community Contract and CQUIN sign off	SDRR52	Open	Contracting	Chief Fin Officer	Jwilmshurst-Smith	Executive	Other / operational	There is a failure to sign off 2015/16 community contracts and their associated CQUINs	Contracting is a prime function of the CCG that impacts across domains of quality, finance and performance	Loss of control over finance and performance of any supplier without a contract	CCG has a contract database and is clear on which contracts and CQUINS are in place however this may not be up to date in respect of community contracts	CCG does not yet have contracts in place for all suppliers,	CCG is in continued negotiation on unsigned contracts and CQUINS.	None known	5	3	15	03/06/2015	09/11/2015	1	1	1	Improving	Min 1-5	Treat	31/05/2015	Risk fully mitigated for this year - revisit in March.
Community Equipment Store	SDRR53	Open	Commissioning	Dir of Comm and Strat	KMcMurray	Executive	Other / operational	There is a risk that the reprocurement of the community equipment store will not meet the needs of patients and carers and / or cause additional cost pressures	Historical issues with the functioning of the community equipment service; lack of clarity and engagement in procurement processes	Potential impact on patients in terms of quality and timeliness of supply of community equipment; CCG may not be able to meet additional financial requirements arising from a new specification.	CCG now engaged in procurement process and has sight of specification and timelines	None known	Joint work with other CCGs and formally through the Section 75 agreement with Surrey County Council	Lack of control over budget operations leading to potential overspends	4	4	16	11/08/015	11/08/015	2	4	8	Static	Low 6-8	Tolerate		Tender has been undertaken (led by Surrey County Council) and is in final stages. CCGs have been invoved in evaluation of tender bids - outcome probable end of November. Issues remain of cost pressures built in to specification - will need to be managed as part of contract mon itoring.
Server Room fire risk	SDRR54	Draft	Corporate	Chief Fin Officer	JPerott	Executive	Other / operational	Fire in the server room could lead to bisuness continuity incident and harm to staff and visitors	Cables unprotected or unidentified; UPS units not sufficiently cooled (fire hazard) or not fit for purpose; combustible material in the room; restricted space may lead to accidents; false ceilings could collapse under weight of cables; installation defects	Harm to staff, business continuity affecting which could impact on delivery of services to patients	Independent audit of server room has identified risks	Probability of any risks being actualised	CCG and CSU are working to resolve/manage risks	CCG and SECSU still to agree their respective responsibility for resolving/managing the risks	3	4	12	02/11/2015	11/11/2015	3	4	12	N/A	Low 6-8	Treat	31/12/2015	CSU and CCG have an action plan - items on the action plan are being progreessed on a weekly basis with the aim of reducing the risk by 31/12/15. Monthly meetings are being undertaken with CSU anfd CCG - Exec to Exec meetings have this as standing agenda item.