NHS
Surrey Downs
Clinical Commissioning Group

Governing Body
18th March 2016

Risk Profile

Agenda Item 11 Paper 7	
Author:	Justin Dix, Governing Body Secretary
Executive Lead:	Matthew Knight, Chief Operating Officer
Relevant Committees or forums that have already reviewed this paper:	Risk is a standing item for the all Governing Body Committees
Action required:	For decision
Attached:	CCG risk profile; risk register; assurance framework
CCG Strategic objectives relevant to this paper:	Core business: relevant to all / most objectives
Risk	Subject of paper
Compliance observations:	**Finance:** There are financial risks on the risk register and achieving a sustainable financial position is on the assurance framework as one of the CCG's core objectives.
	Engagement : No specific issues.
	Quality impact: The quality team identify the potential quality impact of any risks and these are discussed with the quality committee
	Equality impact: No specific issues although formal impact assessments are conducted and risks identified from these.
	Privacy impact: No specific issues.
	Legal: No specific issues

EXECUTIVE SUMMARY

- Risk for March is relatively “flat” as mitigation as in many areas risk is related to the planning and assurance cycle.
- 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 Sustainability and Transformation Plans and the potential for the UK to leave the EEC are potentially factors in evaluating strategic risk in future.
- The risk register shows some variations on M10 and there are one new risk and some minor changes in risk status.
- The revised performance summary shows that over half the CCG’s risks are outside of tolerance, which suggests that the CCG either needs to push harder on risk mitigation or relax its tolerance levels. Timeliness of risk management is however good with the majority of risks being reviewed every six weeks.
- There are a number of developments taking place in 2016/17 in relation to risk management systems, strategy and annual reporting which are of significance.

Date of paper	11th March 2016
For further information contact:	justin.dix@surreydownsccg.nhs.uk

NHS
Surrey Downs
Clinical Commissioning Group

Risk Profiles - Month 12 (March 2016)

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

- Risk for March is relatively "flat" as mitigation as in many areas risk is related to the planning and assurance cycle.
- 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 Sustainability and Transformation Plans and the potential for the UK to leave the EEC are potentially factors in evaluating strategic risk in future.
- The risk register shows some variations on M10 and there are one new risk and some minor changes in risk status.
- The revised performance summary shows that over half the CCG's risks are outside of tolerance, which suggests that the CCG either needs to push harder on risk mitigation or relax its tolerance levels. Timeliness of risk management is however good with the majority of risks being reviewed every six weeks.
- There are a number of developments taking place in 2016/17 in relation to risk management systems, strategy and annual reporting which are of significance.

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 with a brief summary below.

In summary the framework reflects cautious improvements in two areas, namely achieving financial balance and implementing agreed strategies as the CCG has finished the year strongly in these areas, although there is still much to do going forward.

Clinical Priority 1: Maximise integration of community and primary care based services with a focus on frail older people and those with LTC	The CCG is developing an agreed vision for integrated care with Epsom St Helier, CSH Surrey and emerging networks of GP providers. This needs investment and resourcing The CCG is now working with South West London CCGs as part of a programme covering South West London and Surrey Downs. At the same time it is in the process of confirming its main footprint for future sustainability and transformation within the Surrey health system. There are now a number of integration related projects coming on stream which may mean mitigation of the current high score is possible.	**16**
Clinical Priority 2: Provide elective and non-urgent care, specifically primary care, care closer to home and improve patient choice	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.	**12**
Clinical Priority 3: Urgent Care; Ensure access to a wider range of urgent care services	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. The winter period so far has shown normal stresses on the local system but nothing to change the current level of risk.	**6**

Clinical Priority 4: Enhanced Support for End of Life Care Patients	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. Individual projects being delivered e.g. falls strategies are now working within these frameworks.	**8**
Clinical Priority 5: Improve experience of Children's 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 including a recently completed CAMHS procurement.	**6**
Clinical Priority 6: Improving patient experience and parity of esteem for people with Mental Health and Learning Disabilities (including Dementia)	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. Positive developments include IAPT and a Safe Haven (crisis cafe) in Epsom.	**12**
Non-clinical priority 1: Implement 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. This should be accelerated through the work on the five year forward view. At year end there is more assurance that agreed strategies such as the financial recovery plan, community hospitals review and end of life care strategy are having an impact and the revised score reflects this.	**12**

Non-clinical priority 2:Improve 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 have been turned into recommendations that are now being implemented.	**12**
Non-clinical priority 3:Develop 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 has given the CCG clear actions for organisational development. These have been signed off by the member practices and combined with changes to the Committees and Executive Portfolios and a programme for new clinical leadership appointments mean that the CCG is now in a much better position than at the start of the year.	**8**
Non-clinical priority 4:Achieve financial balance	The CCG has a very tightly managed QIPP programme. The organisation and its member practice have ownership of the FRP and the organisational development work (above) will support delivery of the FRP. The 2016/17 challenge will be significant but the risk score (whilst still red) has been cautiously amended to reflect the embedded culture of delivery a financial sustainable health economy.	**16**

Profile 2: Operational risk

The 36 risks on the CCG risk register as of the 8th March are as follows:

	Risk to child safeguarding	
	Transfer of chemotherapy commissioning	
	Catastrophic Provider failure	
	Infection Control	
	Safeguarding Adults	
	Quality of care in Care Homes	
	Major incident preparedness	
	Business continuity	
	Constitution	
	Homecare medicines safety	
	SECAmb Cat A Performance	
	Capacity and surge planning	
	GP IT infrastructure	
	Acute Contract and CQUIN sign off	
	2016/17 Contract planning cycle	
Provider development	Contract database	
Financial impact of failure to achieve quality premium in 2016/17	Failure to control the acute contract portfolio - impact on Financial balance	
Continuing Care Retrospective Reviews (Previously Unassessed Periods of Care) team capacity	Cancer wait 62 days	Governing Body and Committee effectiveness
Failure to achieve 2016-17 QIPP	Community Equipment Store	CHC Retrospective claims impact on Financial balance in 215/16
Stroke mortality and morbidity	Server Room health and safety	Failure to control prescribing costs - impact on Financial balance
CHC IT Transition and data management	CSU Resilience	Impact of transfer of specialist commissioning liability on Financial balance
CHC Safeguarding alerts	Immunisation - Safety	Community Contract and CQUIN sign off
CHC File handling and storage	IT Migration	Stroke mortality and morbidity

Below is a summary of risk performance in relation to these 36 areas.

RISK PERFORMANCE SUMMARY AS AT 8th MARCH 2016

Quantum of risk

	Number
Risks as at last report	39
Closed risks following last report	-4
New risks	1
Total number of open risks	36

Balance of risk

	Number	%
Number of high (red) risks	8	22%
Number of amber (medium) risks	22	61%
Number of green (low) risks	6	17%

Risk appetite

	Number	%
Risks within tolerance	14	39%
Risks outside of tolerance	22	61%

Timeliness of updating

	Number	%
Number of risks not reviewed in last 8 weeks	0	0%
Number of risks reviewed in last 6-8 weeks	5	14%
Number of risks reviewed in last 6 weeks	31	86%

Cross reference to assurance framework

	Number	%
1 Integration of care	1	3%
2 elective and non urgent care	0	0%
3 Urgent Care	2	6%
4 End of life care	0	0%
5 Children and Maternity	1	3%
6 Mental Health and LD	0	0%
7 Strategy	1	3%
8 Quality and Performance	12	33%
9 Organisational Development	3	8%
10 Financial Balance	5	14%
Other / operational	11	31%

Risk Sector

	Number	%
CHC	5	14%
Commissioning	5	14%
Contracting	4	11%
Corporate	3	8%
Medicines Management	2	6%
EPRR	3	8%
Finance	6	17%
Performance	2	6%
Quality	6	17%

Age of risk

	Number	%
More than 2 years	14	39%
1-2 Years	11	31%
6-12 Months	9	25%
3 - 6 Months	1	3%
< 3 months	1	3%

Shift in risk

	Number	%
Worse	0	0%
Better	3	8%
Static	32	89%
N/A (new)	1	3%

Assurance oversight by Committee

	Number	%
Audit	9	25%
Finance and Performance	14	39%
Quality	12	33%
Remuneration and nominations	1	3%

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 (positive or negative)	Long term impact
Local changes	• Surrey devolution requires changes to NHS configuration • Divergence in Surrey CCG approaches to hosting impacts on organisation1	Probable	Certain
Overlapping footprints causing divergent aims	• Sustainability and Transformation Plan (STP) impacts on local (Surrey Downs) plans • Surrounding CCG Programmes e.g. South West London impact on Surrey Downs	Probable	Certain
Political uncertainty	• European Referendum (June 2016) may shift economic context and international policy in several areas	Unclear	Potentially significant
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

Developments in risk management

Annual report

The CCG is required to include a statement -The Annual Governance Statement (AGS) – in its 2015/16 annual report. This identifies its internal control arrangements over the previous year, including a summary of how it handled risk. A draft version of this was shared with the Audit Committee on the 26th February and will be developed and form part of the overall Annual Report. Governing Body members will have an opportunity during the period between now and the end of May to review this and comment on it, although it should be noted that much of the content of the AGS is mandated by NHS England.

Objective setting / assurance framework

The CCG's assurance framework is built on clarity of objectives. It is widely acknowledged that the current objectives need to be reviewed and it is imperative that this work is completed early in the new financial ear to ensure that the assurance framework has something to measure.

Revised risk management strategy

A revised Risk Management strategy will be circulated for agreement at the May Governing Body. Governing Body members will be invited to contribute to this. It will incorporate the learning from the 2015 external reviews and other developments highlighted in the Audit Committee and by auditors. It will also incorporate standardised CCG specific training materials developed during 2015 and the use of Datix (see below).

A key request has been for the CCG's approach to risk management to be more customised and for risk to be guided by how it operates in different areas, e.g. quality, finance, operational etc., using examples that guide managers in assessing risks.

Governing Body and Leadership Development

There will be a need to do training with the new Governing Body and the Clinical Cabinet on risk management and ensure that there is a stronger culture of risk management across the organisation. This will include access to both training materials and personal development, and use the revised risk management strategy as its basis.

Implementation of Datix

The CCG spent a day with Datix at the end of February where the system use was reviewed and a set of project aims developed. There is now a programme of work to develop Datix locally, beginning with the development of a coding structure for the database. This will be done in conjunction with staff that will use the system and will cover incident reporting and complaints as well as risk management. A separate module will cover Freedom of Information.

It is normal with the implementation of a system like Datix for it to change the perceptions and behaviours of staff and for this to lead to an increase in risk reporting. This may be helpful and appropriate, but part of the re-writing of the risk strategy will be to set clear criteria for when, why, how and where risk is recorded and subsequently reported using the new system and to ensure that this supports the objectives and responsibilities of the organisation rather than being a process that takes on a life of its own.

Justin Dix
Governing Body Secretary

March 2016

Organisational Objective	Risk Area	Risk Owner (old)	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)	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	Delivery	Chief Op Officer	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	4	4	**16**	Treat	8	31/03/2015	**Static**	The CCG is developing an agreed vision for integrated care with Epsom St Helier, CSH Surrey and emerging networks of GP providers. This needs investment and resourcings The CCG is now working with South West London CCGs as part of a programme covering South West London and Surrey Downs. At the same time it is in the process of confirming its main footprint for future sustainability and transformation within the Surrey health system. There are now a number of integration related projects coming on stream which may mean mitigation of the current high score is possible.	**12**	**15**	**16**	**16**	**16**	**16**
Clinical Priority 2: Provide elective and non-urgent care, specifically primary care, care closer to home and improve patient choice	Delivery	Dir of Comm and Strategy	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.	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**	**16**	**12**
Clinical Priority 3: Urgent Care; Ensure access to a wider range of urgent care services	Access	Dir of Comm and Strategy	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	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. The winter period so far has shown normal stresses on the local system but nothing to change the current level of risk.	**6**	**6**	**6**	**6**	**6**	**6**
Clinical Priority 4: Enhanced Support for End of Life Care Patients	Patient Experience	Chief Op Officer	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.	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. Individual projects being delivered e.g. falls strategies are now working within these frameworks.	**8**	**8**	**8**	**8**	**8**	**8**

Organisational Objective	Risk Area	Risk Owner (old)	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)	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 5: Improve experience of Children's and maternity services	Patient Experience	Dir of Comm and Strategy	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	2	3	**6**	Tolerate	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 including a recently completed CAMHS procurement.	**6**	**6**	**6**	**6**	**6**	**6**
Clinical Priority 6: Improving patient experience and parity of esteem for people with Mental Health and Learning Disabilities (including Dementia)	Patient Experience	Chief Op Officer	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	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. Positive developments include IAPT and a Save Haven (crisis cafe) in Epsom.	**12**	**12**	**12**	**12**	**12**	**12**
Non-clinical priority 1: Implement agreed strategies	Strategy	Dir of Comm and Strategy	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.	3	4	**12**	Treat	9	31/03/2015	**Improving**	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. This should be accelerated through the work on the five year forward view. At year end there is more assurance that agreed sgrategies such as the financial recovery plan, community hopsitals review and end of life care strategy are having an impact and the refised score reflects this.	**16**	**16**	**16**	**16**	**16**	**12**

Organisational Objective	Risk Area	Risk Owner (old)	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)	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 2:Improve quality and performance of commissioned services	Quality and Performance	Chief Officer	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	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 have been turned into recommendations that are now being implemented.	12	12	12	12	12	12
Non-clinical priority 3:Develop the organisation	Organisational Development	Chief Officer	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;	2	4	8	Treat	8	31/03/2015	Improving	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 has given the CCG clear actions for organisational development. These have been signed off by the member practices and combined with changes to the Committees and Executive Portfolios and a programme for new clinical leadership appointments mean that the CCG is now in a much better position than at the start of the year.	16	16	20	20	12	8
Non-clinical priority 4:Achieve financial balance	Finance	Chief Fin Officer	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	4	4	16	Treat	4	31/03/2015	Improving	The CCG has a very tightly managed QIPP programme. The organisation and its member practice have ownership of the FRP. and the organisational development work (above) will support delivery of the FRP. The 2016/17 challenge will be significant but the risk score (whilst still red) has been cautiously amended to reflect the embedded culture of delivery a financial sustainable health economy.	20	20	20	20	20	16

Title of risk	ID	Executive Risk Owner	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)	Net initial Score	Number of days on risk register	Days since last revieweed	Likelihood Score	Impact Score	Revised Net Score	Trend (change since last Governing Body report)	Risk Appetite range for this category of risk	T Value (Treat, Tolerate, Terminate or Transfer)	If "Treat", set target score at which risk can be tolerated or terminated	Actions and Comments
Provider development	SDRR07	Dir of Comm and Strat	FPC	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	16	393	1	4	4	16	Static	Low 6-8	Treat	8	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 SUrrey Hearltands STP and supporting South West London programmes both of which 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	Interim Dir of Clin Perf and Delivery	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	12	1053	20	2	4	8	Static	Min 1-5	Treat	4	Following discussions with Guildford and Waverley CCG (host for Children's services) there is now scope to ensure that the SDCCG risk in this area matches that of the host.Extensively discussed at January Quality Committee. Broad assurance received but agreed action to develop more SDCCG specific assurance information. Score to remain static.
Transfer of chemotherapy commissioning	SDRR09	Interim Dir of Clin Perf and Delivery	Quality	8 Quality and Performance	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)	15	554	1	3	4	12	Static	Low 6-8	Treat	5	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.
Catastrophic Provider failure	SDRR11	Dir of Comm and Strat	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	16	1053	20	2	4	8	Static	Low 6-8	Tolerate	N/A	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	Dir of Comm and Strat	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.	16	1053	20	3	3	9	Static	Min 1-5	Treat	6	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. Reviewed Feb 2016 - no significant changes in reported activity against plan - loss of specialist surrey wide expertise in March still not assured for future. Score unchanged but needs careful monitoring.
Safeguarding Adults	SDRR13	Chief Op Officer	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.	12	1053	20	3	4	12	Static	Min 1-5	Treat	4	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. Updates against this plan have been given to Audit Committee and Quality Committee (Jan 2016) - further action plan monitoring report requestd for March Quality Committee. Score unchanged.

Title of risk	ID	Executive Risk Owner	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)	Net initial Score	Number of days on risk register	Days since last reviewed	Likelihood Score	Impact Score	Revised Net Score	Trend (change since last Governing Body report)	Risk Appetite range for this category of risk	T Value (Treat, Tolerate, Terminate or Transfer)	If "Treat", set target score at which risk can be tolerated or terminated	Actions and Comments
Quality of care in Care Homes	SDRR15	Chief Op Officer	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.	12	398	20	4	3	12	Static	Low 6-8	Treat	6	Development of a Surrey-wide dashboard still ongoing. Lack of Capacity will probably prevent achieving desired tolerance levels unless additional resource provided. Project Initiation Document (PID) signed off by CHC programme Board andnow proceeding to business case.
Financial impact of failure to achieve quality premium in 2016/17	SDRR18	Dir of Comm and Strat	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	16	1072	1	4	4	16	Static	Low 6-8	Treat	8	Quality premium was lost in 15/16 - risk renewed for 2016/17
Major incident preparedness	SDRR19	Chief Op Officer	Audit	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.	16	1072	1	1	4	8	Improving	Min 1-5	Tolerate	10	EPRR assurance including Major Incident preparedness noted by Governing Body Nov 2015. Further training/exercieses to be arranged. New resource bought in (specialist EPRR expertise) to give CCG more resillience.
Business continuity	SDRR22	Chief Op Officer	Audit	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	15	1072	1	2	4	8	Static	Low 6-8	Tolerate	8	Business continuity plans updated January 2016. Further mutual aid arrangements being discussed with partner organisations.
Constitution	SDRR25		Audit	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	12	1072	1	3	4	12	Static	Medium 9-12	Tolerate		Score reduced from 16 to 12 as Council of Members has approved constitutional changes.These have been submitted to NHSE for signoff - outcome awaited. May need to be revisited if NHSE approval not received by final week in March.
Governing Body and Committee effectiveness	SDRR26	Chief Fin Officer	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	12	1072	1	2	3	6	Static	Low 6-8	Tolerate	8	Monitor operation of revised committees through to July then consider removing from risk register.

Title of risk	ID	Executive Risk Owner	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)	Net initial Score	Number of days on risk register	Days since last reviewed	Likelihood Score	Impact Score	Revised Net Score	Trend (change since last Governing Body report)	Risk Appetite range for this category of risk	T Value (Treat, Tolerate, Terminate or Transfer)	If "Treat", set target score at which risk can be tolerated or terminated	Actions and Comments
CHC Retrospective claims impact on Financial balance in 215/16	SDRR27	Chief Fin Officer	FPC	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	16	1071	1	1	3	3	Static	Low 6-8	Tolerate	N/A	There are now risk pooling arrangements in place (and there was an underspend in 2014/15). Remains low risk.
Homecare medicines safety	SDRR29	Interim Dir of Clin Perf and Delivery	Quality	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	12	597	49	4	3	12	Static	Medium 9-12	Tolerate	N/A	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.
SECAmb Cat A Performance	SDRR32	Dir of Comm and Strat	FPC	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	12	858	1	4	3	12	Static	Low 6-8	Treat	8	Full update paper given to March Governing Body. Commissioners working together on remedial action and appropriate sanctions - will need to be revisited again in April.
Capacity and surge planning	SDRR34	Dir of Comm and Strat	Audit	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 remedial action is not taken.	16	1072	1	2	4	8	Static	Low 6-8	Tolerate	8	Currently risk reduced as system working relatively well as a result of seasonal trends, other than some issues in the Kingston and Epsom areas over winter. System resillience forums in place and specialist funding allocated. Easter being closely monitored.
GP IT infrastructure	SDRR35	Chief Op Officer	Audit	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.	16	1072	1	2	4	8	Improving	Medium 9-12	Treat	9	Installation now rolling out following conclusion of negotiations with NHS England.
Continuing Care Retrospective Reviews (Previously Unassessed Periods of Care) team capacity	SDRR37	Chief Op Officer	FPC	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	16	1071	2	4	4	16	Static	Low 6-8	Treat	8	Down from 6 to 16 as a result of slippage in provider trajectory - being pursued actively with them.

Title of risk	ID	Executive Risk Owner	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)	Net initial Score	Number of days on risk register	Days since last reviewed	Likelihood Score	Impact Score	Revised Net Score	Trend (change since last Governing Body report)	Risk Appetite range for this category of risk	T Value (Treat, Tolerate, Terminate or Transfer)	If "Treat", set target score at which risk can be tolerated or terminated	Actions and Comments
Acute Contract and CQUIN sign off	SDRR41	Chief Fin Officer	FPC	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	15	285	51	4	3	12	Static	Min 1-5	Treat	4	Process ongoing. At end of January 100% of contracts had been signed, excluding AQPs which are subject to a separate process.
2016/17 Contract planning cycle	SDRR42	Chief Fin Officer	FPC	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.	16	285	51	3	4	12	Static	Low 6-8	Treat	4	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	Chief Fin Officer	FPC	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	16	654	51	3	3	9	Static	Low 6-8	Treat	4	Database now functioning but community and smaller contracts needs to be monitored before further review of this risk and risk score. Remains outside of tolerance.
Failure to achieve 2016-17 QIPP	SDRR44	Chief Fin Officer	FPC	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.	20	604	1	4	4	16	Static	Low 6-8	Treat	8	Bottom up analysis of 15/16 schemes completed and £9.8 m remains the plan. Some work on ensuring individual project actions identified as part of that review are implemented. The PMO is now tracking delivery against the QIPP profile that emerged from that review which has enabled us to tie milestones more closely to benefit delivery. Programme Delivery Board terms of reference have been reviewed and strengthened.
Failure to control the acute contract portfolio - impact on Financial balance	SDRR46	Dir of Comm and Strat	FPC	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.	20	581	1	2	4	8	Static	Low 6-8	Tolerate	8	Net score reduced from 16 to 8. Acute over-activity has been largely defined through negotiatrions including agreeing year end position with Epsom St Helier.
Failure to control prescribing costs - impact on Financial balance	SDRR47	Interim Dir of Clin Perf and Delivery	FPC	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.	9	581	1	2	3	6	Static	Low 6-8	Tolerate	N/A	Prescribing costs running within budget - no indications of excessive run rate this stage. No change to risk score.

Title of risk	ID	Executive Risk Owner	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)	Net initial Score	Number of days on risk register	Days since last reviewed	Likelihood Score	Impact Score	Revised Net Score	Trend (change since last Governing Body report)	Risk Appetite range for this category of risk	T Value (Treat, Tolerate, Terminate or Transfer)	If "Treat", set target score at which risk can be tolerated or terminated	Actions and Comments
Cancer wait 62 days	SDRR48	Dir of Comm and Strat	FPC	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.	12	467	1	3	3	9	Static	Zero 1-5	Treat	4	Net risk down from 12 to 9 in January. The trust's action plan is being updated and kept under review by the Quality Committee. Improving position in most specialties.
Impact of transfer of specialist commissioning liability on Financial balance	SDRR49	Chief Fin Officer	FPC	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.	16	581	1	1	4	4	Static	Low 6-8	Tolerate	N/A	Net risk reduced from 8 to 4. £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. To refresh in 2016/17.
Community Contract and CQUIN sign off	SDRR52	Chief Fin Officer	FPC	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	15	279	1	1	1	1	Static	Min 1-5	Treat	4	Risk fully mitigated for this year - revisit in March.
Community Equipment Store	SDRR53	Dir of Comm and Strat	FPC	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.	16	210	1	2	4	8	Static	Low 6-8	Tolerate		Tender has been undertaken (led by Surrey County Council) and provider appointed. Issues remain of cost pressures built in to specification - will need to be managed as part of contract monitoring.
Server Room health and safety	SDRR54	Chief Fin Officer	Audit	Other / operational	Fire or faults in the server room could lead to bisuness continuity incident and possibly harm to staff and visitors	Health and safety issues arising from age of equipment and installation	Harm to staff, business continuity affecting organisation which could impact on delivery of services to patients	12	127	1	2	4	8	Improving	Low 6-8	Tolerate	6	Remedial works almost complete - once testing and assurance in place, may be removed from risk register

Title of risk	ID	Executive Risk Owner	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)	Net initial Score	Number of days on risk register	Days since last reviewed	Likelihood Score	Impact Score	Revised Net Score	Trend (change since last Governing Body report)	Risk Appetite range for this category of risk	T Value (Treat, Tolerate, Terminate or Transfer)	If "Treat", set target score at which risk can be tolerated or terminated	Actions and Comments
CSU Resilience	SDRR55	Chief Fin Officer	Remcom	9 Organisational Development	South East CSU will not be able to deliver contracted services due to operational issues, specifically leadership and recruitment to key roles.	CSU is currently experiencing high levels of turnover and issues with organisational resilience	Potential loss of ability to deliver contracting support, but also continued issues with loss of support in areas such as IT, IG and HR. Different service areas have different levels of resilience and risk.	16	108	1	3	4	12	Static	Low 6-8	Treat	8	The CCG is aware that SECSU is in financial difficulties. The CCG's main risks are within ICT, acute contracts and BI; the CCG is assigning members of the finance team to the three key acute contracts for oversight purposes. The CCG is also working with the Surrey Collaborative on using the Lead Provider Framework to reproduce the ICT element., see Chief Officer's report to the March Governing Body
Immunisation - Safety	SDRR56	Chief Op Officer	Quality	8 Quality and Performance	Medication errors will occur as a result of lack of systemised approach to immunisation in Primary Care	Poor Understanding of the training requirements for the safe management and effective delivery of immunisation programmes within individual practices, innappropriate delegation to junior staff, lack of awareness about changes to immunisation schedules and requirements to update knowledge and practice.	Actual patient harm through medication errors, cold chain breaches, failure to apply the principles of consent to an individual basis	12	253	56	3	4	12	Static	Low 6-8	Treat	4	13.01.16 Further review - Systems and Practice not embedded in some practices. Further work needed within localities led by PCWT and GP Tutor
Stroke mortality and morbidity	SDRR57	Dir of Comm and Strat	Quality	3 Urgent Care	Risk that stroke outcomes for patients will remain below acceptable levels at Epsom and SASH unless surrey stroke review can address isssues relating to appropriate service configuration	Failure of local services to meet standards set out in established national guidance	Actual harm to patients if they are not treated at centres with the required level of expertise appropriate to their clinical needs.	20	1	48	3	1	3	Static	Min 1-5	Treat	5	Surrey commissioners are working with their local health systems to develop the best approaches for delivering the whole pathway of care. The requirements would be clearly laid out regarding the 'must dos' for pathway delivery and an appropriate timescale agreed.
CHC IT Transition and data management	SDRR59	Interim Dir of Clin Perf and Delivery	Quality	8 Quality and Performance	The level of service and support does not enable an efficicent and effective IT to allow business as usual activities. System functionality therefore poor, responsiveness of 'cloud hosted' database slow. Repeated printer failures leave periods of time when we are unable to produce lettters and copy documents. Inability of staff working remotely to access system	Transfer to new CSU IT provider, reduced service desk provision. Existing copier machines are overused and are becoming increasingly difficult to repair. Remote access problematic since switch to new service supplier	Difficulty accessing main patient database, disconnections , loss of data and system functionality. My lose the ability to print documents reuqired as part of the assessment and outcomeing process, Inability for clinicians to access r ecords remotely is causing both inefficiency in time and resource and delays in assessment outcomes for patients.	16	343	1	4	4	16	Static	Low 6-8	Treat	8	As main database is cloud hosted and all patient records are accessed via Citrix link it is critical that the system is accessible at all times to allow clinicians to remotely access and to deal with time critical decisions relating to patient welfare by reference to their records. Connectiviey and response times in the office are also. CSU now engaging in citrix issues, action plan in process for data management issues. Printer issues now resolved.
CHC Safeguarding alerts	SDRR60	Interim Dir of Clin Perf and Delivery	Quality	8 Quality and Performance	Risk that safeguarding alerts could be missed	Poor understanding of the Safeguarding pathway by CHC nurses	Decisions could be made regarding care arrangement without a full understanding of current safeguarding concerns regarding specific sites	16	778	1	4	4	16	Static	Min 1-5	Treat	6	15.01.16 No engagement obtained from safeguarding team. Spreadsheet is not best vehicle for engagement and often out of date, communication between social services and safeguarding team has been an issue as seasonal pressures have identified care agencies that are closed to NHS but open to LA. Post safeguarding alert, raised with EC.

Title of risk	ID	Executive Risk Owner	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)	Net initial Score	Number of days on risk register	Days since last reviewed	Likelihood Score	Impact Score	Revised Net Score	Trend (change since last Governing Body report)	Risk Appetite range for this category of risk	T Value (Treat, Tolerate, Terminate or Transfer)	If "Treat", set target score at which risk can be tolerated or terminated	Actions and Comments
CHC File handling and storage	SDRR61	Interim Dir of Clin Perf and Delivery	Audit	8 Quality and Performance	Member of staff will injure themselves whilst manually handling boxes of files	insufficient appropriate storage facilities within the working area, coupled with high volumes of paperwork necessary to be used on a dialy basis	Staff injury and claim	16	414	1	4	4	16	Static	Low 6-8	Treat	6	Delays in implementing paperless project - short procurement being pursued
IT Migration	SDRR62	Chief Fin Officer	Audit	9 Organisational Development	The CCG will experience a business continuity disruption as a result of further iT migration and / or a period when systems are niot functioning optimally	Planne IT migration during 2016 when the CCG ceases to purchase IT support from South East CSU	Loss of IT servvvices with consequent impact on core business and on hosted services	12	0		2	4	8	N/A	Low 6-8	Tolerate	6	The CCG is working with other CCGs on a planned IT migration and has emploued project support to this end.