Organisational Objective	Risk Area	Risk Owner (Executive)	Main responsible committee	Risk Manager	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)	Assurance (What do we know that gives us confidence in meeting the objective)	Gaps in assurance (What don't we know that could undermine achievement)	Controls (what can we do to have a positive impact)	Gaps in Controls (what do we lack control over)	Actions (reference other action documents rather than describe actions in detail)	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	Pre-mitigation Impact Score	Pre mitigation Likelihood Score	Net initial Score	Date of initial score	Latest Score			Trend	Comments
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	Quality	**Helen Cook**	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	This priority is programme managed and delivery is assured through the PMO and there is a significant programme for the CHC Transformation Project	Benefits realisation is currently under-developed and the CCG has no dashboard for measuring benefits in some programme areas	Contractual changes to service delivery; actions agreed through transformation boards; actions to reform CHC	The CCG is limited in its ability to direct the actions of other agencies in some areas e.g. nursing homes, community equipment, patient transport	CHC Programme; individual programmes under this heading	Treat	8	31/03/2015	5	3	15	01/04/2014	5	3	15	**Static**	This priority is made up of 9 individual project areas for 2014-15, including Continuing Health Care
Clinical Priority 2: Provide elective and non-urgent care, specifically primary care, care closer to home and improve patient choice	Delivery	Chief Op Officer	Quality	**JWagstaff**	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.	There is good information on how Surrey Downs CCG benchmarks against other comparable and national CCGs in relation to care pathways and best practice.	Reaction to the primary care offer cannot be easily predicted and is an ongoing development.	Contractual changes to service delivery; actions agreed through transformation boards; actions to reform primary care supply including development of the primary care offer.	Take-up of the primary care offer is not mandatory; contractual reforms may not operate to the timescales that best fit CCG milestones for transformation.	Primary Care offer development work; individual programmes under this heading; continued development of the Referral Support Service	Treat	8	30/03/2015	4	4	16	01/04/2014	4	4	16	**Static**	There are 20 specific projects associated with this clinical priority of which 6 are associated with pathway redesign in specific areas, and 4 with primary care development. The others mainly concern operational changes and / or adoption of best clinical .practice
Clinical Priority 3: Urgent Care; Ensure access to a wider range of urgent care services	Access	Chief Op Officer	Quality	**JWagstaff**	Failure to provide access to urgent care	Urgent care will not be properly co-090rdinated in particular that it will not be managed properly in primary care	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	The CCG has access to a wide range of data sources on best practice and local usage of urgent care services.	There are no know significant gaps in assurance	The CCG can use contractual levers and work through transformation boards and urgent care boards to improve urgent care co-ordination	There are often data lags in information about use of urgent care; work with p[primary care is linked to other initiatives and incentives; urgent care boards can highlight areas for action but not mandate them.	See Out Of Hospital Strategy and work of urgent care boards.	Treat	6	31/03/2015	3	4	12	01/04/2014	3	4	12	**Static**	There are no formal projects against this objective as it is considered to be "business as usual".

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Clinical Priority 4: Enhanced Support for End of Life Care Patients	Patient Experience	Chief Op Officer	Quality	**Sarah Raheem**	Failure to improve the end of life care experience	End of Life Care services will be inadequate	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.	Current levels of service and how they compare to best practice are known as are the deficiencies in information sharing between primary care and other sectors.	There is a lack of qualitative data on patient experience	The CCG can implement improved data sharing with member practices and commission improved night time services	The CCG does not have operational control over other agencies	Timescales and actions are set out in relevant projects	Treat	8	31/03/2015	3	4	12	01/04/2014	3	4	12	**Static**	There are four projects associated with this priority focusing on improved information sharing, better nightime services and care pathway improvements.
Clinical Priority 5: Improve experience of Children's and maternity services	Patient Experience	Chief Op Officer	Quality	**Kate Taylor**	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	Current levels of service and how they compare to best practice are known.	There are no significant gaps in assur4ance (data is good)	Contracts with main providers, work with primary care	A lot of service provision can only be improved with the support of other agencies e.g. Surrey County Council and NHS England which the CCG has no direct control over]	Individual children's projects as set out under delivery	Treat	6	31/03/2015	3	4	12	01/04/2014	3	4	12	**Static**	There are 12 projects associated with this priority including CAMHS integration, acute and community interface for paediatrics, personal health budgets, and improvements in therapy services.
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	Quality	**Peter Wade**	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	Whole system collaborative groups (incl working groups) are well-established to prioritise MH operational plans. There is some national published data relevant to these programmes – including intelligence tool from MH & dementia networks (Public Health England)	A no of projects are currently only at the mandate stage & there is limited data available for Surrey Downs patients - as these are mostly new projects	Influence the MH & LD Clinical collaborative forum to be action focused rather than just strategy; influence contracts – moving towards more directive, commissioner-led discussions with providers (to increase buyer power), & strengthen working with public health around prevention schemes	A number of pieces of work are joint with other CCGs in Surrey (including initiatives developed in partnership with Surrey H&WB) and can only progress at a jointly agreed pace	See PMO & relevant project mandates for mental health and learning disability	Treat	9	31/03/2015	4	4	16	01/04/2014	4	4	16	**Static**	There are 9 projects within this overall area, including development of a mental health strategy

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Non-clinical priority 1: Implement agreed strategies	Strategy	Chief Officer	Executive	**MNeedham**	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.	Strategies are all in CCG's control and are reported on to the Executive Committee	No significant gaps	The CCG has the ability to establish projects to support the delivery of strategies or component parts of strategies.	Most strategies rely to a greater or lesser degree on partner agency co-operation and collaboration	Actions set out in Out Of Hospital Strategy; Quality Improvement Strategy; Mental Health Strategy	Treat	9	31/03/2015	4	3	**12**	01/04/2014	4	3	**12**	**Static**	
Non-clinical priority 2:Improve quality and performance of commissioned services	Quality and Performance	Chief Op Officer	Quality	**EClark**	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	The CCG has assurance with major suppliers from regular contract meetings and through quality initiatives at local and county level; also from published performance information; initiatives such as visiting programmes; county wide monitoring e.g. of infection control	Performance data often has long time lags meaning it is not up to date; some areas are not commissioned directly by the CCG e.g. specialised services.	Use of contract levers and penalties; joint working on areas of quality improvement; CQUINs	Not always possible to undertake direct action if the contract sits with a host commissioner	Actions set out in action log of quality committee	Treat	8	31/03/2015	3	4	**12**	01/04/2014	3	4	**12**	**Static**	
Non-clinical priority 3:Develop the organisation	Organisational Development	Chief Officer	RNHR	**KParsons**	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;	Regular review of vacancies with CSU; testing of staff attitudes via staff survey; benchmarking against other CSUs e.g. for sickness absence; Framework of Excellence programme (see comments).	No significant gaps	Ability to set own organisational structure; ability to work with staff to align workforce to objectives; control over committee terms of reference	Constitution must have NHS England approval	Organisational Development Plan (in development)	Treat	8	31/03/2015	3	4	**12**	01/04/2014	3	4	**12**	**Static**	The CCG is participating in the Governing Body Framework of Excellence programme which should give assurance and possibly act as a control in the are of Governing Body development as part of the wider OD agenda.

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Non-clinical priority 4:Achieve financial balance	Finance	Chief Fin Officer	Executive	**SRowlands**	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 plus local data and intelligence	Time lags in getting activity and finance information on key suppliers	Ability to agree end of year position with major suppliers; contract levers; process for contract challenges.	Key areas such as CHC, specialist services, and medicines are difficult to manage in a "real time " way	See QIPP programme projects; projects e.g. for medicines management and CHC	Treat	4	31/03/2015	4	4	**16**	01/04/2014	4	4	**16**	**Static**	